STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146046	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Rehab & Nursing	410 North Second Street Marshall, IL 62441

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35347 Based on observation, interview, and record review, the facility failed to ensure residents' rights to dignified activities of daily living. This failure affects six residents (R11, R14, R15, R16, R31, and R48) of six reviewed for dignity on the sample list of 35. Findings include: 1.) On 4/09/2024 at 12:30PM, five tables were pushed together in a row, at the center of the facility dining room with residents seated around the perimeter of the tables. Facility staff began serving lunch meals to the residents seated at the tables at 12:30PM, with residents seated at the same table receiving lunch meals within five minutes of each other. R11, R14, and R48 were all seated at the center table waiting for lunch to arrive while watching other residents eat lunch. R11, R14, and R48 did not receive a meal until 1:20PM, fifty minutes after the first meal was served to the adjoined tables. V10 (Activities Aide) was present and reported residents are supposed to eat lunch at 12:30PM. On 4/10/2024 at 12:45PM, no residents seated in the facility dining room had received a meal. On 4/11/2024 at 12:55PM, no residents seated in the facility dining room had received a meal. On 4/11/2024 at 1:20PM, R48 stated meals are late all the time. On 4/12/2024 at 11:46AM, R11 reported meals are late almost every day and usually don't arrive until 1-1:30PM. Resident Council meeting minutes (3/26/2024) document council members reported breakfast, lunch, and dinner meals are often served late. 31642 (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) R15's Minimum Data Set (MDS) dated [DATE] documents R15's Brief Interview of Mental Status (BIMs)score as 12 out of a possible 15, indicating moderate cognitive impairment, on the day of assessment. (interviews of staff documented below indicate R15 is cognitively intact and reliable). The same MDS documents R15 has limited range of motion of bilateral upper and lower extremities, and is occasionally incontinent of bowel and bladder. R15's Care Plan dated 04/09/24 documents the following: R15 currently has an alteration to her ability to care for herself and need assistance due to Activity intolerance, Pain, Weakness.The same care plan documents: R15 requires extensive assistance of two staff for toileting, and peri-care will be completed anytime R15 is toileted and as needed. On 4/10/24, during resident council group, between 10:00 am -10:55 am, R31 (R15's roommate) stated (R15) puts her call light on to be transferred to the bedside commode. It takes two people. Often it will take an hour to an hour and a half. I have heard in the hall, staff (unidentified) say '(R15's) on the call light again'. Then, I hear the response, 'that is just (R15)'. This woman (R15) has had to wait so long she goes (incontinence) in her pants. The other day she (R15) asked me (R31) to help. I can't help her get up on the toilet. (R15) would never complain. I think staff know this, and don't get into a hurry for (to help) her. R31's MDS dated [DATE] documents R31's BIMS score as 15 out of a possible 15, indicating R31 has no cognitive impairment. On 4/11/24 at 9:20 am R15 confirmed she turns on her call light and has to wait long period of time for staff to respond. R15 also stated I don't want to get anyone in trouble. I can't say I have waited a full hour or more. It may just seem like it to me, because I can't hold my bladder and bowel. When I need to go (void bowel or bladder), I need to go sooner then the staff can get (help) to me at times. I have a diaper (incontinence brief) on, and have learned to accept the fact that I may not make it to the commode. I don't like it, but I have accepted it. I know staff are busy. They provide good skin care, when they get to me. There are a lot of people here for them to care for. R15 also stated,I can't get up on my own to sit on the commode. If I could, I would not ever be sitting in my own (slang for urine and feces). On 4/12/24 at 10:25 am V16, CNA stated Yes, there have been times when I found (R15) really wet, and redness on her peri-area (Moisture Associated Skin Damage/MASD). V16 stated, There have been times where she says she had her call lights on for a long time. There are times where the call light isn't on and she thinks it was. I always check to make sure the call light is working. On 4/12/24 at 10:52 V12, Registered Nurse (RN) confirmed R15 has a history of UTI's and Moisture Associated Skin Damage (MASD). V12 RN also stated R15 is alert and oriented and if R15 said she had her call light on, V12, RN would say R15 knows what she is talking about. On 4/12/24 at 11:20 am V3, Assistant Director of Nursing/ Registered Nurse acknowledged It is a dignity issue for any resident to have to wait long periods of time to be toileted. V3 stated R15 's does have a history of MASD, V3 also stated I do expect call lights to be answered within five minutes, and bathroom call lights within a minute.' On 4/12/24 at 12:12 pm V11, Licensed Practical Nurse (LPN) stated R15 and R15's roommate R31 are both alert and oriented. V11, LPN stated if R15 and R31 said the call light was on for a long time and it caused R15 to void incontinent, 'it must have happened. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility pamphlet titled 'The Illinois Long Term Care Ombudsman Program Residents' Rights for People in Long Term Care Facilities' revised 11/18 documents the facility must treat residents with dignity and respect and must care for you in a manner that promotes your quality of life. 41970 3.) R16's undated Face Sheet documents medical diagnoses of Traumatic Brain Injury, Dysphagia, Hallucinations, Alzheimer's Disease, Need for Assistance with Personal Care, and Cognitive Communication Deficit. R16's Minimum Data Set (MDS) dated [DATE] documents R16 is severely cognitively impaired. This same MDS documents R16 requires maximum assistance for dressing, bathing, toileting and personal hygiene. R16's Care Plan intervention dated 3/8/24 documents R16 is independent with eating. On 4/9/24 at 11:20 AM R16 was seated in a wheelchair, in the hallway. R16 was wearing a grey t-shirt with dried liquid spots down the front, and wet spot that extended from the left midsection of R16's shirt, to side of R16 wheelchair. R16 had fruit loops sitting beside him, on the seat of wheelchair that were touching R16's pants. On 4/9/24 at 2:45 PM R16 was seated in a wheelchair with same soiled clothing, with the same food debris and liquid spots on front of his shirt, as identified earlier in the day as documented above. On 4/10/24 at 10:15 AM R16 was seated in a wheelchair in hallway. R16 was wearing dark blue sweatpants, that had food debris and other circular spots of liquid spilled on R16's pants. On 4/10/24 at 1:30 PM R16 was seated in a wheelchair in hallway with the same clothing on soiled with food debris as observed earlier in day and documented above. On 4/9/24 at 3:00 PM V18, (R16's) Power of Attorney (POA) stated (R16) is partially blind and can't see if his clothes or clean or not. (R16) has Dementia and was never real picky about his clothes. I don't think he would care if (R16) was wearing matching clothes or not, but I know he would not want to wear dirty clothes. They (staff) should change that. On 4/11/24 at 9:15 AM V2 Director of Nurses (DON) stated the facility offers clothing protectors for residents during meal times. V2 DON stated if the resident declines to wear a clothing protector and spills food on themselves, then the staff should offer to assist that resident with changing clothes and 'getting cleaned up'. V2 DON stated Sometimes the resident refuses to change their clothes but the staff should reattempts to help provide hygiene cares. V2 DON confirmed the staff should ensure that dignity of all residents is maintained. The facility pamphlet titled 'The Illinois Long Term Care Ombudsman Program Residents' Rights for People in Long Term Care Facilities' revised 11/18 documents the facility must treat residents with dignity and respect and must care for you in a manner that promotes your quality of life.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 31642 Based on record review and interview, the facility failed to provide mail service on Saturdays. This has the potential to affect all 53 residents that reside in the facility. Findings include: On 4/10/24 at 10:00 am, during the resident group meeting, all residents (R11, R12, R18 and R31) in attendance stated there is no mail delivered to the residents on Saturdays. On 4/11/24 at 9:10 am V5, Activity Director stated Activity staff deliver residents mail everyday (that) there is mail delivered, except on Saturday. We get it from the front office. On Saturday, we would deliver it (to the residents) but it (mail) is locked up. We have no access to the mail that gets delivered (by the post office), until Monday. On 4/11/24 at 9:32 am V14, Human Resource Director/ Front Desk Receptionist stated I sort the mail during the week and give it to Activity staff (unidentified) to deliver to the residents. The post office does deliver mail to the facility on Saturday, but I am not here to sort it. Mail is not getting to the residents on Saturday. It is delivered (to the residents) the following Monday. The facility Long-Term Care Facility Application for Medicare and Medicaid (4/9/2024) documents 53 residents reside in the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to follow-up with physician regarding laboratory results for R40, and failed to ensure only licensed personnel administer medications for R10. R10 and R40 are two of 22 residents reviewed for the provision of skilled care/services on the sample list of 35. Findings include: 1.) R40's Current (multiple dates) Diagnoses Sheet documents the following diagnoses: Unspecified Dementia , Unspecified Severity With Psychotic Disturbance, and Unspecified Dementia, Moderate With Anxiety. R40's Minimum Data Set, dated dated dated [DATE] documents R40 has severe cognitive impairment. R40's Nursing Progress Note dated 03/20/2024 at 3:12 pm documents the following: Note Text: Called and spoke with (V25, Physician's) nurse about aggressive behavior on (of) resident (R40) toward staff, (V25) ordered (laboratory blood test) CBC (Complete Blood Count) and Ferritin (protein that helps the body store iron) level, (and) continue same meds (medications) (,) if (R40) continues to be aggressive (R40) needs sent to psych (Psychiatry). On 4/12/24 at 11:05 am V2 Director of Nursing (DON) reviewed R40 abnormal CBC and low Ferritin laboratory (lab) blood test results dated as drawn 3/20/24. V2, DON confirmed the lab values were abnormal and facsimile (handwritten date of 3/21/24 documented labs faxed at the bottom of R40's lab result sheet) sent to V25, Physician. V2, DON stated her expectation is that the nurses follow-up with a phone call to the doctor if no call back from the Physician in 24 to 48 hours. V2 confirmed the follow-up did not occur until 4/10/24 (after surveyor asked about the labs). V25, Physician ordered and signed the physician order on R40's original 3/20/24 laboratory result sheet. The physician order was dated 4/10/24 and documents Ferrous Sulfate (type of iron to treat anemia) 325 mg, BID (twice a day), repeat (labs) CBC and Ferritin iron studies, in one month. On 4/12/24 at 12:35 pm V25, Physician (R40's) CBC and Ferritin labs were ordered 3/20/24, results were faxed to me 3/21/24. I responded with a return fax to the facility on [DATE]. I requested the current dose of Ferrous Sulfate (R40) was on. I did not receive that information until I was notified by the facility 4/10/24. I should have had a call or return fax with the information identifying (R40's) current Ferrous Sulfate dose, that I requested. I would have addressed this immediately. I do not feel this caused harm or even a potential for harm. I do feel this delay (19 days) should have never occurred. It prevented the start of the Ferrous Sulfate increase. 41970 2.) R10's undated Face Sheet documents medical diagnoses of Paraplegia, Retention of Urine, Need for Assistance with Personal Care, Right Heel Stage 4 Pressure Ulcer, Right Ischium Stage 4 Pressure Ulcer and Muscle Weakness. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's Minimum Data Set (MDS) dated [DATE] documents R10 as cognitively intact. This same MDS documents R10 as requiring maximum assistance for personal dressing, bathing and is dependent on staff for bed mobility. R10's Physician Order Sheet (POS) dated April 2024 documents physician orders to complete urinary catheter care every shift and as needed. R10's Care Plan intervention dated 10/12/22 documents R10 is total dependent on staff for all Activities of Daily Living (ADL). On 4/11/24 at 2:05 PM V19 and V21 Certified Nurse Aides (CNA) completed urinary catheter care for R10. V19 CNA applied Zinc Oxide paste containing 20.6% Zinc to R10's buttocks and perineal area after completing urinary catheter care. On 4/11/24 at 2:30 PM V19 Certified Nurse Aide (CNA) stated V19 applied Zinc Oxide paste to R10's perineal area because that is all we (facility) have. That is what we (staff) always use. I didn't know we (CNA) could not use Zinc. On 4/11/24 at 3:30 PM V2 Director of Nurses (DON) stated only nurses are to apply medicated creams. V2 stated The CNA's are not supposed to apply Zinc. That should only be applied by the licensed nurses since it is considered a medication. I will educate the staff on this. We (facility) do not have a policy on this but it is considered standard of care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on interview and record review the facility failed to provide timely incontinence care for a resident. This failure affects one resident (R15) reviewed for incontinence care on the sample list of 35. Findings include R15's Minimum Data Set (MDS) dated [DATE] documents R15's Brief Interview of Mental Status (BIMs)score as 12 out of a possible 15, indicating moderate cognitive impairment, on the day of assessment. (interviews of staff documented below indicate R15 is cognitively intact and reliable). The same MDS documents R15 has limited range of motion of bilateral upper and lower extremities, and is occasionally incontinent of bowel and bladder. R15's Physician Orders Sheet documents R15 is taking Furosemide (medication to help reduce the build-up of fluid in the body, and increases the production of urine) 40 milligrams daily, for the diagnoses of Shortness of Breath and Edema. R15's Care Plan dated 04/09/24 documents the following: R15 currently has an alteration to her ability to care for herself and need assistance due to Activity intolerance, Pain, Weakness.The same care plan documents: R15 requires extensive assistance of two staff for toileting, and peri-care will be completed anytime R15 is toileted and as needed. On 4/10/24, during resident council group, between 10:00 am -10:55 am, R31 (R15's roommate) stated (R15) puts her call light on to be transferred to the bedside commode. It takes two people. Often it will take an hour to an hour and a half. I have heard in the hall, staff (unidentified) say '(R15's) on the call light again'. Then, I hear the response, 'that is just (R15)'. This woman (R15) has had to wait so long she goes (incontinence) in her pants. The other day she (R15) asked me (R31) to help. I can't help her get up on the toilet. (R15) would never complain. I think staff know this, and don't get into a hurry for (to help) her. R31's MDS dated [DATE] documents R31's BIMS score as 15 out of a possible 15, indicating R31 has no cognitive impairment On 4/11/24 at 9:20 am R15 confirmed she turns on her call light and has to wait long period of time for staff to respond. R15 also stated I don't want to get anyone in trouble. I can't say I have waited a full hour or more. It may just seem like it to me, because I can't hold my bladder and bowel. When I need to go (void bowel or bladder), I need to go sooner then the staff can get (help) to me at times. I have a diaper (incontinence brief) on, and have learned to accept the fact that I may not make it to the commode. I don't like it, but I have accepted it. I know staff are busy. They provide good skin care, when they get to me. There are a lot of people here for them to care for. (V17's Family Member) brings in (brand name pericare barrier) cream and the CNA's (Certified Nursing Assistants) put it on when I have had my accidents (incontinence episodes). I have had a really sore bottom from setting in my wet diaper. The (brand name pericare barrier) is a great comfort. I am not sore now, but I have been many times. The CNA put the (brand name pericare barrier) on at least once per shift. It is a good barrier to prevent the irritation to my skin. I used it on all six of my babies. I still believe it it the best. I can't get up on my own to sit on the commode. If I could, I would not ever be sitting in my own (slang for urine and feces). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/24 at 10:25 am V16, CNA stated Yes, there have been times when I found (R15) really wet, and redness on her peri-area (Moisture Associated Skin Damage/MASD). We use a (brand name pericare barrier) to her peri-areas. There have been times, where she has had to have prescription cream. The nurse gets the order for it. Sometimes she (R15) gets UTI's (Urinary Tract Infections) and she gets sore down there (pericare), then. There have been times where she says she had her call lights on for a long time. There are times where the call light isn't on and she thinks it was. I always check to make sure the call light is working. On 4/12/24 at 10:52 V12, Registered Nurse (RN) confirmed R15 has a history of UTI's and Moisture Associated Skin Damage (MASD). V12 RN also stated R15 is alert and oriented and if R15 said she had her call light on, V12, RN would say R15 knows what she is talking about. On 4/12/24 at 11:20 am V3, Assistant Director of Nursing/ Registered Nurse acknowledged It is a dignity issue for any resident to have to wait long periods of time to be toileted. V3 stated R15 's does have a history of MASD, V3 also stated I do expect call lights to be answered within five minutes, and bathroom call lights within a minute.' On 4/12/24 at 12:12 pm V11, Licensed Practical Nurse (LPN) stated R15 and R15's roommate R31 are both alert and oriented. V11, LPN stated if R15 and R31 said the call light was on for a long time and it caused R15 to void incontinent, 'it must have happened'. V11, LPN stated I have put (R15) on the bedside commode myself, recently. She had wet (urinated) in her brief by the time I took her to the bathroom, but I wouldn't say she was very red, maybe slightly. I guess being wet for any length of time, when she is continent most of the time, would be a dignity issue.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to follow a physician ordered pressure ulcer treatment and implement pressure ulcer interventions for one (R10) of two residents reviewed for Pressure Ulcers on the sample list of 35. Findings Include: R10's undated Electronic Medical Record (EMR) documents medical diagnoses of Paraplegia, Retention of Urine, Need for Assistance with Personal Care, Left Ischium Stage 4 Pressure Ulcer, Right Gluteal Stage 4 Pressure Ulcer, Right Heel Stage 4 Pressure Ulcer and Muscle Weakness. R10's Minimum Data Set (MDS) dated [DATE] documents R10 as cognitively intact. This same MDS documents R10 as requiring maximum assistance for personal dressing, bathing and is dependent on staff for bed mobility. R10's Physician Order Sheet (POS) dated April 2024 documents physician orders to cleanse R10's Left Ischium with wound cleanser, apply thin layer of Hydrogel then cover with bordered gauze dressing daily and as needed. This same POS documents a physician order to cleanse Right Gluteal, cleanse area with wound cleanser, loosely pack tunnel and wound bed with Calcium Alginate rope, then cover with silicone foam dressing daily and as needed. *may use plain packing if Calcium Alginate rope not available. R10's Care Plan intervention dated 10/12/22 documents R10 requires total dependence on staff for all Activities of Daily Living (ADL). This same careplan documents an intervention dated 1/5/23 to turn and position (R10) every two hours/(R10) to only be on back when eating. This same careplan documents an intervention dated 1/5/23 to apply treatment as ordered by Physician. R10's Wound Assessment and Plan dated 4/10/24 documents R10's Left Ischium Stage 4 Pressure Ulcer as Declined due to development of slough and unstable eschar. On 4/10/24 at 9:35 AM R10 was laying on his back in reclined wheelchair in room. R10 stated My butt hurts. I want to lay down. On 4/10/24 at 1:40 PM R10 was laying on his back in reclined wheelchair in room. R10 stated I have been up all morning. My butt hurts. On 4/11/24 at 9:00 AM R10 was laying on his back in reclined wheelchair eating breakfast in the dining room. R10 stated I hope I don't have to stay up all day again. That really hurts my butt. On 4/11/24 at 2:00 PM R10 was being assisted to bed per staff. R10 stated I have been up all day again. Sometimes I like to stay up but my butt hurts a lot lately and I want to lay down more. On 4/10/24 at 10:00 AM V19 Certified Nurse Aide (CNA) stated (R10) does not lay down after breakfast. (R10) stays up until after lunch. V19 stated it is difficult to reposition someone while laying in a reclining wheelchair. On 4/11/24 at 2:50 PM V20 Licensed Practical Nurse (LPN) completed R10's Pressure Ulcer dressing changes. V20 LPN did not cleanse R10's Left Ischium prior to cleansing pressure ulcer. V20 LPN applied Calcium Alginate with Silver to R10's Right Ischium Pressure Ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/24 at 3:15 PM V20 LPN stated V20 did not review R10's physician orders prior to completing dressing change. V20 LPN stated V2 DON wrote the physician orders on a piece of paper and V2 had written the orders down wrong. V20 LPN stated the packages for the Calcium Alginate and Calcium Alginate with Silver are very similar looking. V20 LPN stated I just picked up the wrong dressing. I should have used the regular Calcium Alginate. I forgot to cleanse (R10's) Left Ischium. That could cause an infection. On 4/11/24 at 3:45 PM V2 Director of Nurses (DON) stated nurses should always cleanse a resident's wounds prior to applying new dressing. V2 DON stated not cleansing an open wound as the physician orders could cause a wound to get infected. V2 DON stated the physician orders were not followed for R10's Right Gluteal Stage 4 Pressure Ulcer wound. V2 DON stated We (facility) do not have a policy for a clean dressing change. I consider that standard of care. All nurses should have been taught that in nursing school and would be expected to follow that same teaching at our facility.

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Marshall Rehab & Nursing	410 North Second Street Marshall, IL 62441

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed repeatedly to adequately supervise a resident (R40) at risk for self harm, and failed to document a resident (R159) fall into the facility's risk management system, initiate neurological checks, conduct a fall investigation, determine a root cause, and implement a specific fall intervention to aid in future fall prevention. These failures affect two of five residents (R40, and R159) reviewed for accidents/supervision on the sample list of 35. Findings include: 1.) R40's Current (multiple dates) Diagnoses Sheet documents the following diagnoses: Unspecified Dementia , Unspecified Severity With Psychotic Disturbance, and Unspecified Dementia, Moderate With Anxiety R40's Minimum Data Set, dated dated dated [DATE] documents R40 has severe cognitive impairment and uses a wheelchair for mobility. R40's Care Plan dated 04/04/24 documents the following: I currently have an alteration in my behavior status r/t (related to) Anxiety, Depression, Res (resident) preference to not follow medical recommendations '(noncompliance)', Aggressive Behavior '(Physical or Verbal)', Agitation, Crying/Tearful, Restlessness, (and) Yelling out. Interventions include: Intervene as necessary to protect rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. I currently have an alteration to my Mood status d/t (due to) Restlessness, anxiousness, and exit seeking. Cognition wise, I am not able to understand some commands or questions. I am known for coming out of my room looking for food therefore, I take any food I find, even if it's others and I take objects that aren't food and put in my mouth to try and eat. I am known for verbal aggression and repetitive statements. R40's same Care Plan documents: Behavior- Agitation/ Restlessness/ Anxious. Behavior- eating/ licking inappropriate items. Behavior- taking items that are not mine.' My current risk for Wandering / Elopement is High Risk 7 (score of seven) or higher and my safety will be monitored every shift by all staff. R40's Behavior Note dated 3/3/2024 at 2:10 pm documents the following: Note Text: Resident was in the front lobby and grabbed a bottle of lotion off of the desk it was taken from the resident as he wouldn't give it back he then picked up a wooden out going mail box and threw it across the floor towards the copy room and was cursing at staff. Resident removed from front lobby and taken to his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R40's Nursing Progress Note dated 03/06/2024 at 12:15 pm documents the following: Note Text: CNA came to this nurse with the fact that resident had put some calazime cream in his mouth called poison control spoke with (proper first name only) to see what we needed to do since it was a keep out of reach of children warning label was told to give him a drink of water milk or juice, water was given and he drank without issues V/S T 97.9 P 76 R 18 B/P 116/56 O2 sat at 98% on room air. He might experience some GI upset vomiting or diarrhea if excessive call back but to just watch resident. R40's Behavior Note dated 03/10/2024 at 3:12 pm documents the following:Note Text: Resident had been in and out of his room numerous times, attempting to take stuff off the carts, trash bags and going to the dinning room to eat off other residents used trays, then going to the nurses carts shaking the drawers to attempt to get in them, resident has been redirected several times given snacks, talking with him ,watching his tv (television). Continues to come behind the nurses desk looking for food. Has took (taken)decorations from the desk and then he places them under his blanket to hide them. Goes to the dinning room and gets into the condiments and licks the packages. Became verbally aggressive with the cna (unidentified, Certified Nursing Assistant) when the cna asked for the trash bags back give those back u (you) son of a (expletive). R40's Nursing Progress dated 3/11/2024 at 2:10 pm documents the following: Note Text: Reported to (proper first name only) at (V25, Physician) office about resident attempting to eat things that are non edible, items such as kleenex, oxygen tubing, lancets, paper clips and getting into staffs purses and bags behind the nurses station. Not currently on anything for anxiety. R40's Behavior Note dated 3/17/2024 at 10:43 am documents the following: Note Text: Resident grabbed a bottle on hand sanitizer and took the lid off and this nurse took bottle from resident and he took the top of the bottle and threw it at the wall behind B hall med cart. Screaming at this nurse to go to my room. Attempts to redirect resident met with resistance. R40's Behavior Note dated 3/17/2024 at 11:25 am (37 minutes after the last incident documented above) documents the following: Note Text: Resident was in the front lobby and picked up a small bottle of hand sanitizer and took a drink and stated 'that killed me honey it burns it burns' (.) Called poison control and was asked by (proper first name only) what the ingredients were and told her ethyl alcohol 80% she told this nurse to give him something to eat to help absorb the alcohol it was like drinking a shot of scotch he didn't need to go to the hospital. R40's Behavior Note dated 3/20/2024 at 10:11am documents the following: Note Text: Resident has been very agitated this AM taking Easter decorations off the table and trying to eat the Styrofoam egg had 2 (two) eggs in his mouth and staff had to place fingers on his cheeks to get the eggs from resident's mouth to prevent him from sucking the eggs down his throat (,) he was then taken to his room and given a snack and some water (.) he then went across the hall and opened a bottle of lotion and tried to drink it, staff removed the lotion and he threw the lid across the room and cursed at staff, before breakfast trays were picked up he was eating off multiple trays this nurse removed him from the dining room and was cursed at he also drew back his fist as if to hit this nurse. R40's Nursing Progress Note dated 3/20/2024 at 3:12 pm documents the following: Note Text: Called and spoke with (proper first name only) (V25's) nurse about aggressive behavior on resident toward staff ordered CBC (Complete Blood Count) and Ferritin level continue same meds if continues to be aggressive needs sent to psych (Psychiatry). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R40's Behavior Note dated 4/3/2024 at 10:25 am documents the following: Note Text: Resident was waiting outside the shower room when he went into a female residents room and got in her bedside table and was trying to eat lotion before staff took the lotion and removed resident from the females room and was taken to the dining room until time for his shower. On 4/10/24 at 10:00 am, during a resident group meeting R31 stated R31 saw R40 in the dining room doorway. R40 had approached an unlocked medication cart, while V11, Licensed Practical Nurse (LPN) was passing medications. V11's back was turned. When V11 turned back around she saw R40 had removed a large bag from the drawer of the medication cart. 'The bag was full of something, I think it was medication and blood test vials.' R31 also stated V11 knew if R40 got away with those medications it could really hurt him. R40 started swinging at V11. R40 was arguing with V11. (V11) and (R40) were in a tug of war for a minute. V11 got the bag away from R40. R40 was taken back to his table to eat. During the same group meeting R18 stated he saw the same event occur between R40 and V11, exactly as R31 had described. R18's Minimum Data Set (MDS) dated [DATE] documents R18's Brief Interview of Mental Status (BIMS) score as 15 out of a possible 15, indicating no cognitive impairment. R31's MDS dated [DATE] documents R31's BIMS score of 15 out of a possible 15, indicating no cognitive impairment. On 4/11/24 at 11:55 am R40 was seated in a recliner in his room. R40 had a throw blanket over his head and hummed loudly when surveyor knocked on R40's door. R40 removed the blanket from his head and said over and over I love you. When asked any question, R40 hummed or would say I love you. R40 was unable to answer any questions. R40 had three empty plastic glasses and an empty snack bowl on his bedside table. On 4/11/24 at 12:05 pm V15, Certified Nursing Assistant stated she works with R40 all the time. V15, CNA stated He (R40) is always into to something. We try to watch him close. I was off the day he got stuff out of the medicine cart and hit (V11, Licensed Practical Nurse). I heard about it the next day. That was a couple weeks ago. I was not surprised. He can be easily re-directed but is consistently taking stuff off the medicine carts. Staff intervene daily. We all know to watch him every minute. He has dementia and doesn't know better. It is up to us to give him something to do. He is a good eater. We give him snacks a lot. He will try to eat other things he should not be eating. He just doesn't understand. He can get agitated with us. He has never been agitated with another resident, that I know about. On 4/12/24 at 10:10 am V16, CNA stated R40 grabbed a potted plant on the nurses station and another time he had taken another residents a gift set of shampoo, body wash and lotion set. V16 said she assumed he was going to eat it and got V26, LPN. V16, CNA also stated R40 has taken the water pitcher off of the med cart and V16 has seen him shake the drawers of the med cart. V16 also stated an unidentified CNA saw R40 drink pericare liquid wash. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/12/24 at 12:12 pm V11, LPN confirmed she provided care to R40 (3/17/24) when R40 consumed a good size swallow of hand sanitizer in the lobby, and had tried earlier the same day to drink the hand sanitizer at the nurses station. V11 had to call poison control and was directed by V25, Physician to follow poison control recommendations. V11 also stated she was R40's nurse when he had gotten medicated Calazime cream in his mouth (3/6/24). V11 stated R40 had gone into the shower room that day and had already got the medicated cream when an unidentified CNA saw R40 and reported. V11 stated she had to call V25, Physician and Poison Control. V11 stated R40 needs constant supervision sometimes because he puts thing in his mouth that are not food. V11 also stated On the weekend we do not have ancillary staff. Those days are very hard to keep constant eye on him (R40) if he is having one of those days where he is busy and trying to put stuff in his mouth. We intervene a lot those days. When ancillary staff are here, they see him and redirect too. Those extra eyes make a difference when he is really active. On 4/12/24 at 12:35 pm V25, Physician stated she has observed staff fail to supervise R40 as closely as they should, on the weekend. V25 also stated it is expected, knowing R40 history, that staff stay diligent in supervising him. 32172 2.) The facility Fall Reduction Policy dated 6/17/22 documents all falls should be documented in the residents electronic medical record and the risk management report and fall risk assessment should be completed after each fall. If the fall is not witnessed neurological checks should be initiated. Nursing staff should update the 24 hour report. The resident's care plan should be reviewed after every fall and updated with a new intervention. R159's Medical Diagnoses List dated April 2024 documents R159 is diagnosed with Repeated Falls, Psychotic Disorder, Mild Cognitive Impairment, Dementia, Motor and Sensory Neuropathy, and Muscle Weakness. R159's Minimum Data Set, dated dated dated [DATE] documents R159 is severely cognitively impaired, uses a wheelchair, and requires substantial assistance for chair/bed transfer and toilet transfers. R159's Fall Risk assessment dated [DATE] documents R159 is high risk for falls due to dementia diagnoses, he has three or more falls in past three months, he is ambulatory and incontinent, has balance problems while standing and walking, requires assistive devices, and has at risk medications and at risk diagnoses. R159's Nurses Progress Note dated 4/3/24 documents R159 continues to be on fall follow-up protocol (from a fall on 3/31/24) and had another fall at 10:00 PM (on 4/2/24) when he was attempting to self-transfer to his wheelchair to use the bathroom. There is no other documentation concerning this fall on 4/2/24. Neurological checks were not initiated. A fall investigation was not completed. A root cause was not determined and a new, root cause specific intervention was not implemented. R159 fell again on 4/9/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/12/24 at 11:15 AM V2 Director of Nurses confirmed R159 had an unwitnessed fall on 4/2/24 at approximately 10:00 PM which was not entered into the risk management system, neurological checks were not initiated, a fall investigation and root cause was not determined, and no new fall interventions were implemented to aid in future fall prevention.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to check the placement of a Percutaneous Endoscopic Gastrostomy (PEG) tube prior to administration of medication and enteral feeding for one (R37) out of one resident reviewed for PEG tubes in a sample list of 35 residents. Findings include: R37's undated Face Sheet documents medical diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Aphasia, Cerebrovascular Disease and Dystonia. R37's Minimum Data Set (MDS) dated [DATE] documents R37 as severely cognitively impaired. R37's Care Plan intervention dated 2/12/24 instructs staff to check for Percutaneous Endoscopic Gastrostomy (PEG) tube placement and gastric contents/residual volume per facility protocol and record. R37's Physician Order Sheet (POS) dated April 2024 documents a physician order starting 3/7/24 to administer Jevity 1.5 calorie at (55 milliliter/hour). Check for placement and residual amount prior to administration. This same POS documents physician orders for Glycopyrrolate Oral Tablet (Glycopyrrolate) one milligram (mg) via PEG-Tube three times a day for ulcers and Metronidazole 500 milligrams (mg) per PEG tube three times a day for infection for 6 Weeks for infection. On 4/10/24 at 12:09 PM R37 V13 Registered Nurse (RN) administered R37's Metronidazole 500 milligrams (mg) and Glycopyrrolate 1 mg per R37's Peg Tube without checking for residual prior to medication and water flush administration. V13 RN then resumed R37's Jevity 1.5 enteral feeding after medication administration without checking for residual. On 4/10/24 at 12:20 PM V13 Registered Nurse (RN) stated R37 has an order to check R37's Peg tube placement daily. V13 RN stated I am not sure what the policy says but we (staff) do not check the residual before each medication administration or starting or stopping (R37's) feeding. We only check it once a day. On 4/10/24 at 4:20 PM V2 Director of Nurses (DON) stated the nursing staff should always check the placement of R37's PEG tube prior to administering any medications, water flushes and/or enteral feedings. V2 DON stated it is important to check the placement to ensure the medications, water and feeding is 'going to the right place'. The facility policy titled 'Tube Feeding' initiated November 28, 2023 documents the staff providing medication administration should verify the Physician's order, gather equipment, identify resident, provide privacy, explain procedure to resident, assist resident to semi-or high Fowler's position (30 degrees to 45 degrees) unless contraindicated, perform hand hygiene and apply gloves, prepare medication, unclamp tube, attach a 60 cc syringe into the tube, verify tube placement check for residual gastric contents by aspirating the syringe, return gastric contents removed during residual check back into stomach, insert syringe (without plunger) and flush tube with 30 cc water; do not use cold water which may induce abdominal cramping,

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to provide, change, date and maintain respiratory equipment according to physician orders and facility policy. This failure affected three of three residents (R8, R22. and R31) on the sample list of 35. Findings include: 1.) R8's Physician Order Sheet (POS) dated 4/9/24 documents the following: O2 (Oxygen) at (administer) 4L (four liters per minute) PRN (as needed), if sat (blood oxygen saturation) below 85 '(Notify Physician)', every 15 minutes as needed for SOB (Shortness of Breath). The respiratory administration device is not documented. R8's same POS documents: Change Humidifier Bottle (with) date and time on bottle of (sic) change every night shift every 7 day (s) for Oxygen (sic) use refillable humidifier bottle change date and time on bottle of change (sic). R8's same POS documents R8 is on Hospice end of life care. On 4/9/24 at 12:00 pm, V28, R8's Family Member was seated at R8's bedside. R8 was asleep with an oxygen nasal cannula present in her nares. R8's oxygen concentrator was actively dispersing four liters of oxygen per minute. R8's oxygen tubing with the nasal cannula were not dated or timed as to when they had last been changed. R8 did not have a humidifier bottle attached to the (valve) of the oxygen concentrator. V28 stated V28 is not sure if the oxygen tubing has been changed and is not sure if R8 has had a humidifier bottle of water on her oxygen concentrator. V28 stated It seems it would be more comfortable if she did. comfortable. On 4/9/24 at 12:05 pm ,V11, Licensed Practical Nurse stated R8 is on Hospice. Hospice was suppose to bring in their own supplies for R8. V11 confirmed R8 does not have a humidifier bottle on her concentrator and the tubing and nasal cannula are not dated to indicate when they were last changed. 2.) R22's POS dated 4/10/24 documents the following: Oxygen at 2 L/min (liters per minute) via Nasal Cannula, Humidification as needed. Change Humidifier Bottle, date and time on bottle of (when) change (d) every night shift, every 7 day(s) for Oxygen use Refillable (sic). On 04/09/24 at 12:25 pm R22 was not in R22's room. R22's oxygen concentrator was dispensing oxygen at 2 liters per minute via a nasal cannula. The nasal cannula tubing was draped on top of and around an oxygen concentrator machine. There were no date or time documented on R22's oxygen tubing, nasal cannula or humidifier water bottle to indicate when the respiratory equipment had last been changed. On 4/9/24 at 12:30 pm V11, LPN confirmed the observation of R22's oxygen tubing being draped around R22's concentrator, undated tubing and cannula, and actively dispensing oxygen when R22 was not using the oxygen. V11 stated the respiratory equipment should have been changed. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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. 35347 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 53 in the facility. Findings include: On 4/9/2024 at 10:58AM, V8 (Dietary Manager) was actively supervising dietary operations in the facility kitchen. V8 reported being the full-time manager of the facility food service and reported not being a clinically qualified Certified Dietary Manager or having equivalent training. V8 denied meeting the State of Illinois standards to be a food service manager or dietary manager. V8 reported the facility dietician does not work full-time in the facility. V8 denied: -being a dietician; -being a certified dietary manager; -having an associate's or higher degree in food service management or in hospitality; -having 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting; -being a graduate of a dietetic and nutrition school or program authorized by the Accreditation Council for Education in Nutrition and Dietetics, the Academy of Nutrition and Dietetics, or the American Board of Nutrition; -being a graduate, prior to July 1, 1990, of a Department (Illinois Department of Public Health) approved course that provided 90 or more hours of classroom instruction in food service supervision and having experience as a supervisor in a health care institution which included consultation from a dietician; -or having completed an Association of Nutrition & Foodservice Professionals approved Certified Dietary Manager or Certified Food Protection Professional course. On 4/9/2024, the facility dietary staff failed to prevent direct cross-contamination of food and failed to maintain sanitary food storage areas. On 4/12/2024 at 11:50AM, V8 reported the food prepared in the facility kitchen is available for all residents to eat. The facility Long-Term Care Facility Application for Medicare and Medicaid (3/9/2024) documents 53 residents reside in the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 31642 Based on interview and record review, the facility failed to provide residents food at an appetizing temperature for four of four resident (R11, R12, R18, and R31) reviewed for palatable meals on the sample list of 35. Finding include: R11, R12, R18 and R31's Current, Minimum Data Sets document R11, R12 R18 and R31 all have Brief Interview of Mental Status scores of 15 out of a possible 15, indicating they have no cognitive impairment. On 4/10/24 at 10:00 am during a resident group meeting, R11, R12, R18 and R31 their meals were often served late, up to one and a half hours past the scheduled meal time, resulting in hot food being served cold. All residents stated there has not been cold food served since state surveyors arrived in the building 4/9/24. On 4/10/24 at 11:30 am V8, Dietary Manager (DM) stated V8 DM Inherited a lot of kitchen problems when he started as DM two weeks ago. V8, DM stated All the hall trays are delivered to the halls first. We use a disc at the bottom and a cover over the top of the plate to keep the food hot. There have been a lot of complaints. The food comes out of the kitchen at safe hot temperatures, then they set on the hall for 30 to 45 minutes before the aides (Certified Nursing Assistants) get the trays delivered to the resident. I have discussed this with nursing staff. What I hear is, they are busy getting people up and out to the dining room, so they can't deliver the trays yet. The problem happens in the dining room as well. The food is at a safe temperature and brought out to the dining room. I watched a cart, with food set for 30 minutes with the dining room full of residents waiting to eat. There is no problem with the kitchen re-heating the food to a safe temperature. The CNA's just need to let us know. I said something to nursing when I saw the cart of food had not been delivered. That is when the Aides got the trays out to the residents in the dining room. There were a couple residents that asked for their food to be reheated that day. I think it was Monday. The facility Resident Council (meeting notes) Tuesday, January 30, 2024 documents Old Business-Last Month. Some members had several dietary concerns. Food Temps (Temperatures) are documented as one of the concerns Resident Council follow-up. document. The facility Resident Council (meeting notes) Tuesday, February 27, 2024 documents December and January (unidentified council) Members expressed some meals are not warm enough when received. The facility Resident Council (meeting notes) Tuesday, March 26, 2024 document council members reported breakfast, lunch, and dinner meals are often served late, lately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146046	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Rehab & Nursing	410 North Second Street Marshall, IL 62441

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 31642 Based on interview and record review the facility failed to provide bedtime snacks for four of five of four residents (R11, R12, R18 and R31) reviewed for bedtime snacks on the sample of 35. Findings include: R11, R12, R18 and R31's Current, Minimum Data Sets document the following: R11, R12 R18 and R31 all have Brief Interview of Mental Status scores of 15 out of a possible 15, indicating they have no cognitive impairment. On 4/9/24 at 10:00 during a resident group meeting, R11, R12, R18 and R31 stated snacks are not stocked daily or offered at bedtime. The facility sometimes puts the snack cart in the linen room and not at the nurses station, so the resident can't get snacks on their own. R12 and R31 both added they have Diabetics Mellitus and need to have a snack available so their blood sugar level doesn't drop. On 4/10/24 at 11:30 am V8, Dietary Manager stated There should be no problem with snacks at bedtime or between meals. The snack carts are taken to the nurses station, filled on each unit, each shift. I don't know if the snack carts are being put in the linen room. I had not heard that before. On 4/11/24 at 9:00 am V3, Assistant Director of Nursing (ADON) and V2 Director of Nursing (DON) together discussed resident council group meeting concerns with this surveyor. V2, DON stated she was not aware that snacks were not being provided at bedtime. V3, ADON stated The snack cart is put in the linen room because a wandering resident (R40) gets into the snack cart and tries to eat everything, and he (R40) is a diabetic and can't have all the stuff on the cart. V2, DON then stated she will look into a better solution, so all resident have access to the snacks on A, and B halls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146046	A. Building B. Wing	04/12/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35347 Based on observation and interview, the facility failed to prevent direct cross-contamination of stored food and failed to maintain sanitary food storage areas. This failure has the potential to affect all 53 residents residing in the facility. Findings include: 1. On 4/9/2024 at 11:05AM, three wire shelving sections located in the kitchen walk-in cooler were partially covered with a gray-colored, fuzzy biological growth resembling mold. Boxes of food items, pans of prepared food, and jugs of milk were stored directly on these shelving racks. 2. On 4/9/2024 at 11:21AM, the facility walk-in freezer evaporator/condenser supply lines were leaking accumulated condensation onto boxes of food stored below on shelving. The leak had dripped directly into a fully open box of frozen green beans, partially covering the product. At this time, V8 (Dietary Manager) was present and observed the box of green beans. When asked if the ice on the green beans was condensation that had leaked from the above evaporator/condenser supply lines, V8 replied yes. On 4/12/2024 at 11:50AM, V8 reported food in kitchen is available for all residents to eat. The facility Long-Term Care Facility Application for Medicare and Medicaid (4/9/2024) documents 53 residents reside in the facility.