STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146070	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Willows Nursing Center	1600 North Broadway Salem, IL 62881

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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 - Few	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** 48356 Based on interview, observation and record review the facility failed to promote dignity for 1 of 4 (R17) reviewed for dignity in a sample of 23. Findings included: 1. R17's Admission Record dated 3/8/2022 documents an admitted [DATE] with diagnoses in part of unspecified dementia, dysphagia oral phase, and weakness. R17's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) that interview could not be completed due to R17 is rarely or never understood. Staff interview for mental status documents short- and long-term memory problems. This indicates R17 has severally impaired cognition. Section GG documents under eating that R17 requires substantial to maximal assistance with eating. R17' Care Plan dated 12/20/24 documents under problem: Potential for significant weight loss r/t (related to) GERD (Gastroesophageal Reflux), peptic ulcer, poor appetite, weakness, slow eater, dyspnea. R17 is resistant at times to allow staff assist with meals. R17 tends to take food and smear it on the table. R17 likes milk. Intervention document in part CNA (Certified Nurse Assistant) are to attempt to assist R17 with meals. If R17 does not 50% of meal, a second person is to attempt to assist resident to eat, CNA is to show assigned nurse the tray for verification of intake, and/or potential ideas to increase meal intake, assigned nurse should then attempt to assist R17 to eat, and spoon in each bowl. On 01/13/25 at 11:58AM, R17 was served a tray. The tray was placed in front of R17 with individual bowls and one spoon in a bowl. R17 was then observed placing her fingers in all the bowls and trying to eat the food off her fingers. R17 did try to grab the spoon that was in the bowl, but the spoon flipped out of the bowl on to R17's lap. On 01/13/25 at 12:05PM, an unknown staff member sat down at R17's table and began to assist another resident that was sitting at the table. R17 continued to try to eat with her fingers sticking her hands and fingers in all the bowls and licking the food off of her hands. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/13/25 at 12:10PM, V11 (Certified Nurse Assistant) sat down next to R17 to assist her with eating. V11 wiped off R17's hands and then went to the kitchen and got several plastic spoons and placed them in each of R17's bowls. On 01/13/25 at 12:30PM, observed R17's tray she consumed a 100% of her meal with assistance. On 01/15/25 at 2:52PM, V2 (Director of Nursing) stated that R17 is dependent with eating. V2 said R17's tray should not have been placed in front of her or served to her until someone was available to assist R17 with eating. V2 said that R17's tray should not have been placed in front of her so that she could not put her fingers in her food. On 01/16/25 at 10:43AM, V6 (Certified Nurse Assistant/CNA) stated R17 needs assistance with eating. V6 stated R17's food should never be placed in front of her without someone being there to assist her. 41610

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51735 Based on observation, interview and record review, the facility failed to ensure call lights were within reach for 6 of 7 residents (R1, R5, R11, R19, R21, R24) reviewed for call lights on the sample list of 23. Finding include: 1. R19's Admission Record documents diagnoses including in part dementia and an admitted [DATE]. R19's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 7, indicating R19 has severe cognitive impairment. R19's MDS dated [DATE] documents R21 has had falls with injury, including skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains or any fall related injury that causes the resident to complain of pain since admission/entry or reentry or the prior assessment. R19's Care Plan with review date of 12/27/24 documents a problem area of potential for injury related to falls related to decreased strength. Activities of daily living function decline, cognitive loss, history of falls, intermittent vertigo. R19 does ambulate as desired in room to the bathroom. R19 will often ambulate out in hallway pushing her wheelchair. Interventions for this problem include in part: have call light within reach and encourage R19 to use it for assistance as needed. On 1/13/25 at 9:00 AM, R19 stated no one came to help her out of the bathroom this morning and she had to walk herself back to her chair and her wheelchair was in her way. Call light was in the floor behind the recliner out of reach. R19 stated there isn't a call light, so I guess I will have to crawl across the floor to the bathroom next time. On 1/14/25 at 8:50 AM, R19 was in bed. One call light was in floor behind the recliner and one call light was wrapped around wall light, both call lights were not in reach. 2. R5's Admission Record documents diagnoses including in part dementia and was admitted on [DATE]. R5's MDS dated [DATE] documents a BIMS score of 9, indicating R5 has moderate cognitive impairment. MDS dated [DATE] documents R5 has had falls with injury since admission/entry or reentry or the prior assessment. R5's Care Plan with a review date of 12/23/1024 documented a problem area, Potential for injury related to falls related to decreased strength and periods of confusion. She was admitted from home with a history of dementia, edema (swelling) bilateral extremities, restless leg syndrome, and neuropathy. She ambulates up without assistance with wheeled walker. Sometimes she propels walker backwards and needs reminder to turn walker around. Sometimes, she becomes overly tired with ambulation and needs reminder to sit and rest. She is on Lasix (water pill) therapy. Interventions for this problem include in part: have call light within reach and encourage her to use it for assistance as needed and assist her to the bathroom, chair, etc as needed. On 1/14/25 at 8:57 AM, observed R5 in chair in room, one call light was under the covers on the bed out of reach and the other call light is wrapped around a wall light out of reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/14/25 at 10:17 AM, observed R5 in chair in room, one call light was under the covers on the bed out of reach and the other call light is wrapped around a wall light out of reach. 3. R21's Admission Record documents an admitted [DATE] and diagnoses including in part dementia, major depressive disorder and Alzheimer's disease. R21's MDS dated [DATE] documents a BIMS score of 4 which indicates Severe cognitive impairment. MDS dated [DATE] documents R21 has had falls with no injury and with injury, including skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains or any fall related injury that causes the resident to complain of pain since admission/entry or reentry or the prior assessment. R21's Care Plan with review date of 12/27/24 documents a problem area, potential for injury related to falls related to history of falls, slightly unsteady gait, activities of daily living function decline, cognitive loss, frequent ambulation tires him out. He ambulates ad lib about facility via wheelchair. He will transfer self from wheelchair to chair and back again without locking wheels. Resident and POA direct for resident to be allowed to be ad lib (up as desired) freely. Interventions for this problem include in part: have call light within reach and encourage him to use it for assistance as needed. On 1/13/25 at 1:15 PM, observed R21 in wheelchair in room and call light in floor behind recliner, not in reach. On 1/13/25 at 2:20 PM, observed R21 in wheelchair in room and call light in floor behind recliner, not in reach. On 1/14/25 at 8:59 AM, observed R21 in recliner in room and call light was in floor behind recliner, not in reach. 41610 4. R24's Admission Record documents an admitted [DATE] with diagnoses including: Parkinsonism, anemia, Alzheimer's disease, and cerebral infarction. On 01/13/25 at 9:50 AM, R24's call light was laying on the middle of her bed, approximately 3 feet from her reach. R24 was in her reclined back wheelchair. On 01/13/25 at 11:40 AM, R24's call light was laying on the middle of her bed, approximately 3 feet from her reach. R24 was in her reclined back wheelchair. On 01/13/24 at 1:21 PM, R24 was heard yelling help two times at 1:24 PM when surveyor looked in R24's room to check on R24, V6 (Certified Nurse Aide) came out of a different resident's room and looked down the hall and seen surveyor and asked, did I hear someone yell help ? This surveyor stated, yes and V6 came down and checked on R24. R14 was in R24's room with his wheelchair right next to her reclined wheelchair. R24 stated, I want him out of my room. V6 asked R24, why did you not use your call light? R24 responded, Because I can not reach it. V6 stated, let me get him out of your room and get this call light in your reach. 5. R11's Admission Record documents an admitted [DATE] with diagnosis including Parkinson's disease. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/13/24 at 9:53 AM, R11 was in her recliner, her call light was on the floor over by her bed, not within R11's reach. On 01/13/24 at 2:29 PM, R11 was in her recliner with no call light within her reach. 48356 6. R1's admission record dated 03/27/23 documents an admitted [DATE] with diagnoses in part of anxiety, chronic obstructive pulmonary disease, low back pain and muscle weakness. R1's Minimum Data Set, dated dated dated [DATE] documents in Section C a Brief Interview of Mental Status (BIMS) score of 15 which indicates cognitively intact. Section GG documents independent with toileting. R1 uses a wheelchair and is independent with wheeling self. Walking was not attempted due to medical condition or safety concerns. R1'S Care Plan dated 12/13/24 documents a Problem of Potential for injury r/t (related to) decreased strength, severe kyphosis, and diabetes. Interventions for this problem include in part- have call light within reach and encourage R1 (her) to use it as needed and R1 (she) needs prompt response to all request for assistance. On 01/14/25 at 9:10AM, R1 was sitting in her recliner. R1 had no call light within reach of her. R1's call light was observed on the floor next to her bed. R1's call light was observed 5 feet away (measured with tape measure) from her on the floor. On 01/14/25 at 9:12AM, R1 stated she could see her call light on the floor. R1 said if she needed to use the call light, she might be able to slide down out of her recliner or maybe crawl on to the floor and get the call light. R1 said that she thinks if she needed to get to her call light it might be challenging but she thought that she might be able to reach it if she tried. On 01/15/25 at 2:52PM, V2 (Director of Nursing) stated that every resident in the facility should have a call light next to them when they are in their room. V2 said some residents can't use the call light but that they should still have the call light next to them at all times when in the room in case they need to call for help. V2 stated that R1 is able to use her call light. On 01/16/25 at 10:43AM, V6 (Certified Nurse Assistant/CNA) stated that all residents should always have their call light next to them. V6 said that not all residents can use them, but the call light should be by them at all times when in their room. V6 stated that R1 can use her call light. V6 said that R1 is independent when in her wheelchair but needs help sometimes getting in her chair and she does not walk. On 01/16/25 at 2:52PM, V10 (CNA) stated that all residents should have a call light next to them at all times when in their room in case they need something. V10 said if a resident cannot use their call light, then they should have frequent checks. A Call Lights policy undated documents, call lights are to be available to all residents when in their rooms.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39744 Based on interview, and record review the facility failed investigate a bruise of unknown origin for 1 (R13) of 1 resident reviewed for bruises of unknown origin in a sample of 23. Findings include: R13's Admission Record documents an admitted [DATE] with a diagnosis including: progressive supranuclear ophthalmoplegia (Steele-[NAME]-[NAME]). R13's Minimum Data Set, dated dated dated [DATE] documents a brief interview of mental status (BIMS) score of 2 indicating severely cognitively impaired. R13's nurse's note dated 11/10/24 at 10:00 AM documents: dark purple bruise observed on Rt (right) buttocks (5.5 cm (centimeters) - length, 4.5 cm - width) No open areas. Bruise of unknown origin. Resident denies having any pain or discomfort. Resident does not know how bruise was obtained. POA (power of attorney) aware and the doctor notified with no new orders. No edema to the bruise. On 01/15/24 at 1:22 PM, R13 stated she does not remember what happened when she had the bruise on her bottom. On 01/16/24 at 1:05 PM, V2 (Director of Nursing) stated, she does not have any further information on the injury of unknown origin other than the nurse note. She does remember it being mentioned in a meeting but there is no investigation or report for it. They probably should have. The undated facility policy titled, Abuse Investigations documents: All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by facility management. 1. should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident.

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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** 48356 Based on interview, observation and record review the facility failed to provide necessary services that are consistent with professional standards to prevent the worsening of pressure ulcers for 1 of 2 residents (R4) reviewed for pressure ulcers in a sample of 23. Findings include: R4's admission record dated 03/01/2022 has an admitted [DATE] with diagnoses in part of Type 2 diabetes mellitus, morbid obesity, venous insufficiency, muscle weakness and need for assistance with personal care. R4's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 15 which indicates that R4 is cognitively intact. Section M documents this resident at risk of developing pressure ulcers/injuries answers as yes. Does this resident have one or more unhealed pressure ulcers/injuries answers as no. R4's Care Plan last revised 11/18/24 documents in part a problem of R4 currently has excoriation and darkened areas on his buttocks. R4 is totally incontinent of bowel and bladder. R4 is resistive to lying on his side as a preventative. Interventions include in part 10/20/24 zinc oxide to Lt (Left) hip TID (three times a day) and PRN (as needed) t/h (till healed). R4's Physician's order dated 01/01/25-01/31/25 documents under treatments start date 10/20/24 zinc oxide may apply to area every shift U/H (until healed) L (left) hip. Gold Bond (no start date given) original powder ES (every shift) and PRN (as needed) r/t (related to) MASD (Moisture Associated Skin Damage) prevention apply to buttocks/ABD (Abdomen) folds /peri (perineal) area. R4's Skin Progress notes documents on 11/25/24 Left hip stage II with a diameter 0.5cm (centimeter) x 0. 5cm depth of 0.1cm no drainage no odor progress left hip clean edge and center, 12/02/24 left hip no stage listed a diameter of 0.5cm 0.5cm with a depth of 0.1cm no drainage no odor progress Lt hip pink edge and center, 12/23/24 left hip no stage with a diameter 0.5cm x 0.5cm with a depth of 0.1cm no drainage no odor Lt hip reducing pink edge and center, 12/30/24 left hip no stage with a diameter 0.5cm x 0.1cm with a depth of 0.1cm no drainage no odor progress Lt. hip reducing pink edge and center 01/06/25 Left Hip no stage diameter 0.5cm x 0.1cm with a depth of 0.1cm no drainage no odor progress Lt. hip same pink edge and center. No further notes. R4's treatment record for the month of January documents start date of 10/20/24 zinc oxide- may apply to area every shift U/H L hip with no certain time documented under hours only a schedule of PRN. No signature on treatment record documenting that the treatment had been administered at any time during the month of January for this left help area. On 01/14/25 at 2:00PM, V12 (Registered Nurse) went to perform treatment to R4's buttocks and left hip. V12 stated that she wasn't going to do the treatment to R4 buttocks and hip because the CNA's (Certified Nurse Assistants) do the treatment. V12 said the CNA's usually put the zinc oxide or moisture barrier on R4's buttock and left hip. V12 stated that the treatment was already done for the day and would not be done again until evening shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/14/25 at 2:05PM, V2 (Director of Nursing/DON) stated that the CNA's do not apply zinc oxide to R4's buttocks or left hip that he gets medicated powder to his buttocks and the nursing staff is to apply all treatments. V2 then went to talk to V12 and told her that the CNA's do not do the treatment to R4 that the nursing staff is the one to do the treatments. On 01/14/25 at 2:07PM, V12 stated that she would be able to do the gold bond medicated power to R4 now along with R4's left hip treatment. On 01/14/25 at 2:10PM, V12 went into R4's room where staff was already in room trying to assist with turning R4 on his side so that V12 could perform treatment. At that time V12 (CNA) was removing a foam wedge from R4's left side V12 stated she had to be careful because R4 has a sore area on his left hip. Observed area to R4's left hip which appeared to measure approximately 5cm x 2cm with several spots that appeared open and other parts with scabbed areas on it. No redness noted or drainage. No treatment observed to the area. V12 cleansed area to left hip then removed gloves then completed hand hygiene put on new pair of gloves and applied zinc oxide to left hip area. V12 then cleansed buttocks area removed soiled gloves completed hand hygiene then put on new gloves and applied gold bond medicated powder to buttocks. V2 (DON) was in the room during treatment. On 01/15/25 at 2:52PM, V2 stated that R4 should have had a treatment to his left hip done every day. V2 said that she is aware that R4's treatment to his left hip has not been signed off for any day for the month of January. V2 said she knows that the nursing staff has been doing some kind of treatment to R4's left hip, but she doesn't know what treatment. V2 said if staff didn't think the zinc oxide was a good treatment for R4's left hip then staff should have contacted the doctor and told him that the zinc treatment wasn't working and ask if they could change it to gold bond medicated powder or another treatment that doesn't make the left hip wet. The facility policy titled Decubitus Ulcer (Care and Prevention of) undated documents under Purpose to prevent and treat further breakdown of pressure sores. Under Treatment it documents treatment of decubitus ulcers will vary depending on the orders of the attending physician. The nurse is responsible for carrying out the treatment as ordered by the attending physician and for the implementing measures to prevent decubiti.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51735 Based on observation, interview and record review the facility failed to implement active, cognition appropriate and progressive interventions to prevent falls for three (R5, R19, R21) of six residents reviewed for falls in a sample of 23. Findings include: 1. R5's Admission Record documents diagnoses including in part dementia. Admission Record documents R5 was admitted on [DATE]. R5's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 9, indicating R5 has moderate cognitive impairment. MDS dated [DATE] documents R5 is independent with transfers, has no impairment in the upper or lower extremities and uses a walker for mobility and usually understands others during conversation. R5's MDS documents R5 has had falls with injury, including skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains or any fall related injury that causes the resident to complain of pain since admission/entry or reentry or the prior assessment. R5's Care Plan with a review date of 12/23/2024 documents a problem area, Potential for injury related to falls related to decreased strength and periods of confusion. She was admitted from home with a history of dementia, edema bilateral extremities, restless leg syndrome, and neuropathy. She ambulates up without assistance with wheeled walker. Sometimes she propels walker backwards and needs reminder to turn walker around. Sometimes, she becomes overly tired with ambulation and needs reminder to sit and rest. She is on Lasix (water pill) therapy. Interventions listed without dates include: Anticipate needs to prevent overreaching and obstructions in pathways, educate resident/family/caregivers about safety reminders and what to do if a fall occurs, encourage to participate in activity that promotes exercise, physical activity for neuro needs, self-care management, propelling own wheelchair, and therapeutic gait, she ambulates ad lib (as desired) with wheeled walker, when she is propelling walker backwards, remind her to turn walker around and put hands on brakes for safety reasons, have call light within reach and encourage her to use it for assistance as needed, assist her to the bathroom, chair, etc as needed, and R5 needs activities that minimize potential for falls while providing diversion and distraction. R5's Incident/Accident Report dated 12/10/2024 at 7:50 PM documents R5 states she was trying to sit on bed and sat on edge and slid down. R5 was found in front of bed 1. Report documents that R5 was confused. R5's Post Fall/Incident assessment dated [DATE] documents the resident was advised to scoot back further on bed when sitting down. Assessment documents there were no new interventions added to care plan the intervention was already covered in the current Care Plan. R5's Care Plan included a handwritten note: 12/10/24 Fall: no abrasions, denied hitting head, Neuro's started. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Incident/Accident Report dated 12/17/2024 at 1:20 AM, documents R5 was found on the floor in the hallway. R5 stated she was coming to ask for someone to curl her hair and bumped her head on the wall. Neuro checks as a precaution. No injuries noted. R5's Post Fall/Incident assessment dated [DATE] documents R5 lost balance while walking without her walker. Staff instructed to remind her to use walker when observed without one. Report documents there was a new intervention added to care plan. R5's Care Plan included a handwritten note: 12/16/24 Fall: No bruising, redness, swelling, or abrasions noted, neuros started. 12/18/24 Bruising noted to bilateral lower eyes. R5's Incident/Accident Report dated 12/30/24 at 7:00 PM, documents yelling was heard coming from R5's room. R5 was found in the floor by the door. R5 stated she slipped and hit her head on the wall. Bump to front of head. Denies any other discomfort. Neuro's initiated. Report documents R5 was confused at the time. R5's Post Fall/Incident assessment dated [DATE] documents R5 slipped while using her walker. Thirty-minute visual checks with toileting every 2 hours during waking hours is checked. Assessment documents there were no new interventions added to care plan the intervention was already covered in the current Care Plan. R5's Care Plan with a revision date of 12/23/24, documents no documentation was added pertaining to the 12/30/24 fall. R5's Incident/Accident Report dated 1/9/2025 at 6:00 AM, heard someone yelling and found R5 sitting on the floor by her bed. R5 stated she rolled off her bed and hit her head on the floor. R5 has a bump to top of left side of head and complains of pain to right shoulder. R5's Post Fall Incident assessment dated [DATE] documents resident stated, I must have rolled out of bed and hit my head on the floor. Assessment documents R5 is short and when sits on regular bed her legs are short which causes potential to slip off bed. Resident has a low bed but was trying not sleep in taller bed. Taller bed was removed and her room was rearranged so she could hold onto furniture to increase safety. Thirty-minute visual checks with toileting every 2 hours during waking hours is checked. Report documents there was a new intervention added to care plan. R5's Care Plan included a handwritten note: 1/9/24 Fall: Slid out of bed, high/low bed related to falls and upper siderails on bed related to bed mobility, furniture rearranged for safety, neuro checks and monitor bruising. R5's Incident/Accident Report dated 1/13/2025 at 12:10 AM, documents R5 was found on the floor in room yelling own name. R5 said she fell when she got up from sleeping. R5 was found between bed and dresser on floor. Hematoma (bruise) noted to left side of head and left hand. The report documents R5's bed was in the down position and the resident condition was normal and confused. R5 was taken to local hospital by ambulance. R5's Post Fall/Incident assessment dated [DATE] documents the resident stated, I lost my balance and fell . The assessment documents a question, is it necessary to equip the resident with an alarm device that monitors his/her attempts to rise? The box next it stating device offered along with put in place but resident is not changing her pattern or waiting for help. Thirty-minute visual checks with toileting every 2 hours during waking hours is checked. Report documents there were new interventions added to care plan. R5's Care Plan with a revision date of 12/23/24, documents no new interventions were added after the 1/13/25 fall. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Willows Nursing Center	1600 North Broadway Salem, IL 62881

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's (name of local hospital) physician's orders dated 1/13/25 at 3:40 AM documents R5 to be placed in bed with bed alarm. Ambulation with assistance and walker. On 01/13/25 at 12:41 PM, observed R5 in the dining room after lunch scooting to edge of reclining chair then R5 pushed up to standing. Chair was not locked and was rolling backwards and there was no alarm pad in the chair. Surveyor's intervened R5 from falling then called for help and V5 (Certified Nursing Assistant, CNA) came over to assist resident. V5 assisted resident to standing, then V5 CNA walked with resident with wheeled walker to room with no ambulation belt. Resident had large amount of dark purple bruising and swelling to eyes, lips, cheeks, forehead, and left hand. On 01/14/25 at 08:57 AM, observed R5 in chair in room and personal alarm pad was sitting in a different chair not in use. One call light was under covers on bed out of reach and other call light was wrapped around a wall light out of reach. R5 had more swelling to face and lips and bruising had spread further down neck compared to 1/13/25. On 01/14/25 at 10:17 AM, R5 in chair in room and one call light under covers on bed out of reach and other call light was wrapped around a wall light out of reach. Alarm pad was not under R5. On 01/14/25 at 2:03 PM there was a power box with cord laying in the floor of R5's room in front of R5's bed. R5 was sitting in recliner sitting on chair alarm that is not turned on. On 01/14/25 at 2:05 PM, V9 (Certified Nursing Assistant, CNA) stated that was the power box and cord for R5's recliner that does not work and the box and cord are usually pushed under the bed. V9 stated she doesn't know why it is laying in the floor, it is not hooked up to anything. V9 stated she doesn't know if alarm pad was on, she hasn't used chair alarm pads before and has not received training on it. On 01/16/25 at 10:10 AM, V2 (Director of Nursing) stated she didn't know R5 almost fell and wheels should be locked on chairs when they are pushed up to the table. V2 stated they investigate all falls and on the report, there is a question that asks if the care plan has any new interventions and V2 stated most of the time the resident is covered under the current interventions, and she can't think of a new intervention. V2 stated the thirty-minute visual checks with toileting every 2 hours during waking hours are not charted, they should be in the care plan. V2 stated every resident should have a call light in their room and it should be within reach. 2. R21's Admission Record documents an admitted [DATE] and diagnoses including in part dementia, major depressive disorder, and Alzheimer's disease. R21's MDS dated [DATE] documents a BIMS score of 4 which indicates severe cognitive impairment. MDS dated [DATE] documents R21 has had falls with no injury and with injury, including skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains or any fall related injury that causes the resident to complain of pain since admission/entry or reentry or the prior assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's care plan with revised date of 12/27/24 documents a problem area, potential for injury related to falls related to history of falls, slightly unsteady gait, activities of daily living function decline, cognitive loss, frequent ambulation tires him out. He ambulates ad lib about facility via wheelchair. He will transfer self from wheelchair to chair and back again without locking wheels. Resident and POA direct for resident to be allowed to be ad lib freely. Interventions listed without dates include: anticipate and meet resident's needs to prevent overreaching and obstructions in pathways, have call light within reach and encourage him to use it for assistance as needed, R21 ambulates with wheeled walker. If he does not have his walker, remind him to use it and then assist in locating the walker, encourage to participate in activities that promote exercise, physical activity for strengthening and improves mobility, Restorative therapy, ensure that appropriate footwear with non-skid sole is worn when ambulating or mobilizing in wheelchair, encourage him to take time to rest for periods of time throughout the day, R21 needs activities corresponding with his cognitive level that minimize the potential for falls while providing diversion and distraction, assess his likes and dislikes to encourage meal intake to increase strength, and notify the physician if becomes unstable due to complaints of dizziness or light headedness. R21's Incident/Accident Report dated 4/24/24 at 9:30 PM, documents heard walker fall on floor in room. Found walker tipped over and R21 was laying on the floor. Small skin tear to right forearm. Report is not filled out entirely. Date and time of physician notification is missing. There were no new interventions listed. R21's Incident/Accident Report dated 5/15/24 at 5:00 PM, documents R21 was pivoting into chair at table and slipped causing himself to hit head and causing a 2.5 CM skin tear to right index finger. There were no new interventions listed. R21's Incident/Accident Report dated 6/10/24 at 4:45 AM, documents R21 stated he was trying to use the bathroom and slipped and landed on bottom. Skin tear to left arm. Resident reminded to call for help when trying to take self to bathroom. R21's Incident/Accident Report dated 7/12/24 at 4:12 AM, documents R21 walked up to nurse's station with blood on shirt. Gash to right eyebrow. Blood was on floor next to bed. No indication that physician was notified of fall. Report documents there was a new intervention added to R21's care plan. Thirty-minute visual checks with toileting every 2 hours during waking hours is checked. R21's Incident Reports for 7/13/24, 7/16/24 and 8/16/24 document R21 had falls in which the intervention listed was to do thirty-minute visual checks with toileting every 2 hours during waking hours. R21's Incident/Accident Report dated 10/5/24 at 2:00 PM, documents R21 found sitting on floor at Nurse's Station. Intervention listed was to remind resident to call for help to walk if he is tired. R21's Incident/Accent Report dated 12/6/24 at 2:40 PM, documents R21 transferred self from wheelchair to bed and fell . R21 stated he hit his head. Intervention listed as set up 30-minute checks, dementia, makes poor safety choices. On 1/13/25 at 1:15 PM, observed R21 in wheelchair in room and call light in floor behind recliner, not in reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/25 at 2:20 PM, observed R21 in wheelchair in room and call light in floor behind recliner, not in reach. On 1/14/25 at 8:59 AM, observed R21 in recliner in room and call light was in floor behind recliner, not in reach. 3. R19's Admission Record documents diagnoses including in part dementia and an admitted [DATE]. R19's MDS dated [DATE] documents a BIMS of 7, indicating R19 has severe cognitive impairment. R19's MDS dated [DATE] documents R21 has had falls with injury, including skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains or any fall related injury that causes the resident to complain of pain since admission/entry or reentry or the prior assessment. R19's Care Plan with review date of 12/27/24 documents a problem area of potential for injury related to falls related to decreased strength. Activities of daily living function decline, cognitive loss, history of falls, intermittent vertigo. R19 does ambulate as desired in room to the bathroom. R19 will often ambulate out in hallway pushing her wheelchair. Interventions listed without dates include: anticipate and meet resident's needs to prevent overreaching and obstructions in pathways, have call light within reach and encourage her to use it for assistance as needed, R19 does propel herself about facility in wheelchair. R19 ambulates as desired in room to bathroom. At times she will ambulate to the hallway pushing her wheelchair from behind, encourage to participate in activities that promote exercise, physical activity for strengthening and improve mobility, ensure that appropriate footwear with non-skid sole is worn when ambulating or mobilizing in wheelchair, encourage her to ask for assistance when needed, R19 needs activities corresponding with her cognitive level that minimize the potential for falls while providing diversion and distraction, assess her likes and dislikes to encourage meal intake to increase strength, notify the physician if becomes unstable due to complaints of dizziness or light headedness. R19's Incident/Accident Report dated 4/7/24 at 12:00 PM, documents R19 fell while transferring self to chair. Small laceration to left side of face and broke glasses. Intervention listed as thirty-minute visual checks with toileting every two hours during waking hours is checked. R19's Incident/Accident Report dated 7/29/24 at 6:15 PM, documents R19 fell on way to bathroom. R19 hit the back of her head on bedside table. 4-centimeter gash present to back of head. Pressure was applied until ambulance arrived. R19 was taken to the local hospital by ambulance. Intervention listed as thirty-minute visual checks with toileting every two hours during waking hours is checked. R19's Incident/Accident Report dated 11/7/24 at 1:15 PM, documents R19 was found on floor and hit head on over bed table. Hematoma to right head. Intervention listed as thirty-minute visual checks with toileting every two hours during waking hours is checked. On 1/13/25 at 9:00 AM, R19 stated no one came to help her out of the bathroom this morning and she had to walk herself back and her chair was in her way. Call light was in the floor behind the recliner out of reach. R19 stated there isn't a call light so I guess I will have to crawl across the floor to the bathroom next time. On 1/14/25 8:50 AM, observed R19 in bed. One call light was in floor behind the recliner and one call light was wrapped around wall light, both call lights were not in reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Fall Prevention that is undated documents After a fall has occurred, a post fall/accident assessment shall be completed and turned into the director of nursing and the care plan will be updated to reflect any changes for fall prevention.

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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** 41610 Based on interview, observation and record review the facility failed to follow the facility policy for weight loss for one (R24) resident of 3 residents in a sample of 23. Findings include: R24's Admission Record documents an admitted [DATE] with diagnoses including: Parkinsonism, anemia, Alzheimer's disease, and cerebral infarction. R24's Current Care Plan documents: problem: Potential for excessive weight loss r/t (relating to) forgetting to eat r/t Parkinson's, dementia, Alzheimer's/cognitive loss. R24 tends to be a very pick eater. The intervention section documents: undated interventions of: R24 is on regular diet, likes and dislikes assessment, R24 reports that her favorite foods include meatloaf, potatoes of all kinds, hamburgers, banana pudding, ice cream, she reports that she does not like mixed vegetables, broccoli, spinach or many vegetables of any kind, follow likes/dislikes assessment and honor her other verbal dislikes for food, R24 can feed herself. She does not request alternate foods instead of what is served, if she does not eat what is on her tray, ask if she would like something else instead, offer substitutes for disliked foods, if weight gain persists of 5% in one month, 7.5% in 3 months or 10% in 6 month values, notify the physician, monitor and record meal intake with every meal, monitor for any s/sx (signs or symptoms) of aspiration or dysphagia: choking, fever, coughing, weigh monthly, monitor and evaluate weight, and family supplies nutritional drink as she so choses (by family). R24's Extra Care Plan sheet documents, 10/7/24, Problem #4. Failure to thrive, refusing care, food and drink. Short term goal: to increase food and water intake by 10/30/24. Approach: send to ER (emergency room) for evaluation. The facility document titled weights and vital summary dated 12/04/24 documents weights on: 08/07/24 of 178 pounds, on 09/09/24 of 175 pounds, on 10/18/24 of 166 pounds, and on 11/08/24 on 158 pounds. The facility document located in R24's chart titled, RD (Registered Dietician) Assessment had not been filled out. R24's Quarterly Nutritional Re-evaluation dated 11/04/24 documents: R24's weight is 172 pounds and documents a pressure ulcer to R24's right lower leg. Resident (R24) on regular diet, refused to eat as first but doing better now, weight stable with intakes poor but getting better. R24 nurse notes dated 10/14/24 documents: (R24) returned from hospital on 10/07/24 - 10/14/24 with sepsis EBSL (extended spectrum beta-lactamase) in urine, and BLE (both lower extremities) cellulites. The facility document dated 07/22/24 titled, Malnutrition Risk Assessment documents: total score: total score above 10 represents high risk, the score totaled is listed as 11. This score is the most current listed on the assessment form. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's Physician's Order sheet dated 10/01/24 - 10/31/24 documents an order dated 10/23/24 of: referral to (town name) wound center. The facility document dated 10/03/24 titled, Patient Literal Orders by Category category: diet: documents R24's diet as: regular. There are no supplements documented for R24. On 01/13/24 at approximately 10:30 AM, V15 (Dietary Manager) provided the facility document dated 10/03/24 titled, Patient Literal Orders by Category Category. V15 stated, the document is the updated list of resident diets and supplements. On 01/16/24 at 1:10 PM, V15 (Dietary Manager) stated she does not do anything with weight loss, that information comes from V2 or nursing. They give her any residents with weight loss information, she does not receive their weights or calculate any weight loss. She just receives the order and implements it. On 01/16/24 at 1:40 PM, V16 (Licensed Practical Nurse) stated, R24 was weighed a few days after she returned from the hospital on 10/14/24 and she weighed 166 pounds on 10/18/24. On 09/09/24 she weighed 175 pounds. That is a 9 pound weight loss in around 30 days which is over 5%, but she was given a diagnosis of adult failure to thrive when she returned. Her weight on 11/08/24 was 158 pounds, which was still down some more. She does not know why her chart has different weights listed on different forms, the weights and vital summary sheet is the correct weights. She does not see in her chart where a note or referral was sent to the registered dietician or any supplements given to R24 to assist with any further weight loss. She stated the facility did not do anything to follow through with R24's weight loss including implementing any supplements or forwarding the weight loss information to the registered dietician. She would expect a resident that had been sick or had wounds in conjunction with over 5% weight loss in 30 days would benefit from a nutritional supplement. The undated facility policy titled, Weight and Length Measurement documents: documentation: 1. record date and weight 2. all weights to be completed by the first week of the month. Do according to the schedule. 3. Office nurse - figure the loss or gain the second week of the month. 4. Notify physician by phone, dietary supervisor in writing of: loss or gain: 5% in one month, 7.5% in three months, 10% in six months. 5. If weight loss occurs in the hospital or during any other stay while out of facility, it must be reported to the physician upon return. Resident care plan: 1. Identify weight variance above or below ideal/usual body wt (weight). Assess reason for weight variance. 2. Establish a measurable goal for resident to gain or lose wt as appropriate to attain ideal/usual body weight range. 3. Develop a plan in consultation with the physician and dietician to attain the desired weight gain or loss.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 39744 Based on interview, record review and observation the facility failed to post daily nurse staffing data for licensed and unlicensed staff responsible for resident care. This failure has the potential to affect all 24 residents who reside at this facility. Findings included: On 1/13/2024 at 12:00pm, the facility's daily staff posting was noted on the wall across from the south hall nurses station. The date on the staff posting is noted to be 2/26/24 and documented a census of 32 residents. On 1/14/2025 at 12:00pm, the facility's daily staff posting was noted on the wall across from the south hall nurse's station. The date on the staff posting is noted to be 1/14/25 and documented a census of 24 residents. On 1/15/2025 at 1:00pm, the facility's daily staff posting was noted on the wall across from the south hall nurse's station. The date on the staff posting is noted to be 1/14/25. On 1/15/2025 at 1:00pm, V3 agreed the facility's daily staff posting was not current, but should be and probably just was missed today. On 1/16/2025 at 12:05pm, the facility's daily staff posting was noted on the wall across from the south hall nurse's station. The date on the staff posting is noted to be 1/14/25. The Long-Term Care Facility Application for Medicare and Medicaid form 671 dated 1/14/25 documents there are 24 residents living in the facility.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on observation, interview and record review the facility failed to ensure a resident with dementia received the necessary person-centered care and services to address wandering behavior for 1 of 1 resident (R14) reviewed for Dementia in the sample of 23. Findings include: R14's Admission Record documents an admitted [DATE] with diagnoses including: dementia without behavioral disturbance and altered mental status. R14's Minimum Data Set, dated dated dated [DATE] documents no brief interview of mental status was performed due to resident is rarely or never understood. R14's Current Care Plan does not include any problem area for wandering into other residents rooms. 1. On 01/13/24 at 1:21 PM, R24 was heard yelling help two times at 1:24 PM when surveyor looked in R24's room to check on R24, V6 (Certified Nurse Aide) came out of a different resident's room and looked down the hall and saw surveyor and asked, did I hear someone yell help ? Surveyor replied, yes and V6 came down and checked on R24. R14 was in R24's room with his wheelchair right next to R24's reclined wheelchair. R24 stated, I want him out of my room. V6 asked R24, why did you not use your call light? R24 responded, Because I can not reach it. V6 stated, let me get him out of your room and get this call light in your reach. On 01/13/24 at 1:34 PM, R24 who was alert to person, place and time stated, she just did not want R14 in her room, he doesn't do anything but she just doesn't want him in there. R24 stated, R14 comes in her room often but they take him back out. 2. On 01/13/24 at 2:29 PM, R11 who was alert to person, place and time asked for assistance to have R14 removed from her room, she stated she did not want R14 in her room. R14 had his wheelchair right next to her chair. V13 (Housekeeping) removed R14 from R11's room. 3. On 01/15/24 at approximately 12:55 PM, R7 yelled out for someone to remove R14 from her room. R14 was in his wheelchair and was approximately 2 feet from her bed. On 01/15/24 at approximately 1:03 PM, V13 removed R14 from R7's room. On 01/15/24 at 1:07 PM, R7 who was alert to person, place and time, stated she just didn't want R14 in her room. On 01/16/24 at 10:50 AM, V13 stated R14 does go into other resident's rooms but they just go get him and take him back out. On 01/15/24 at 2:40 PM, V2 (Director of Nursing) stated, the only behavior tracking for R14 is for his medications (Haldol), they do not have any behavior tracking for him for anything else, including wandering. V2 stated, R14's care plan (that was given to the surveyor) is R14's whole care plan, he does not have any other problem areas.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41610 Based on interview, observation and record review the facility failed prevent cross contamination of drinking glasses during meal service. This failure has the potential to affect all 24 residents residing at the facility. Findings include: On 01/13/24 at 11:43 AM, V4 (Certified Nurse Aide/CNA) delivered drinks to the residents in the dining room by the rim of the glass, where the residents drink from, after touching the kitchen door, the drink cart handle, her jeans, and the handles of several wheelchairs without any hand hygiene performed. On 01/13/24 at 11:40 AM, V4 delivered the drink cart to the hall with the drinks in a tote with ice in the bottom and no lids or covering over the drinks. On 01/14/24 at 11:47 AM, V4 delivered drinks to the residents in the dining room by the rim of the glass, where the residents drink from, after touching the drink cart handle, her jeans, and the handles of several wheelchairs without any hand hygiene performed. On 01/14/24 at 11:45 AM, V11 (CNA) was serving uncovered drinks from the hall cart, by the rim after touching the handle of the drink cart and resident's doors. On 01/15/24 at 11:37 AM, V11 delivered drinks to the residents in the dining room by the rim of the glass, where the residents drink from, after touching the drink cart handle, her jeans, and the handles of several wheelchairs without any hand hygiene performed. On 01/15/24 at 1:35 PM, V17 (Dietary) stated drinks should not be delivered by the rims of the glass where the residents would drink from. V17 stated, she was plating food this week, so she is unsure about the hall drinks, but usually they are covered, she does not know why they were not covered, they should have been covered. On 01/16/24 at 10:50AM, V15 (Dietary Manager) stated drinks should not be transferred by the rims of the glass and the hall drinks need to be covered, She will have an in-service with the CNA's about dietary service. The Long-Term Care Facility Application for Medicare and Medicaid form 671 dated 1/14/25 documents there are 24 residents living in the facility.

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	146070	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Willows Nursing Center	1600 North Broadway Salem, IL 62881

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on observation, interview, and record review the facility failed to follow proper infection control technique during incontinent care for 1 of 2 (R4) residents observed for incontinent care in a sample of 23. Findings included: R4's admission record dated 03/01/2022 has an admitted [DATE] with diagnoses in part of Type 2 diabetes mellitus, morbid obesity, venous insufficiency, muscle weakness and need for assistance with personal care. R4's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 15 which indicates that R4 is cognitively intact. Section GG documents toileting as dependent and personal hygiene as substantial/maximal assistance. R4's Care Plan dated 11/18/24 documents in part a problem of R4 currently has excoriation and darkened areas on his buttocks. R4 is totally incontinent of bowel and bladder. R4 is resistive to lying on his side as a preventative. Interventions include in part when incontinent, wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinent episodes. On 01/14/25 at 2:15PM observed V9 (Certified Nurse Assistant/CNA), V10 (CNA) and V11 (CNA) perform incontinent care to R4. V9 and V11 was assisting with holding R4 on his right side while V10 placed gloves on and started to clean R4's left side of his buttocks. V10 was not observed performing hand hygiene prior to placing gloves on. V10 started cleansing R4's buttocks, she wiped over open areas on buttock with cleansing wipes. V10 then started to cleanse the rectum area which had a moderate amount of stool. V10 continued to cleanse R4's rectum area until all the stool was removed. V10 then removed her gloves that were covered in stool and then places a different pair of gloves on without performing hand hygiene. V10 then started to clean R4's groin area. V10 wiped area around groin with cleansing wipes. V10 then started to reposition R4 onto his left side so that V9 could cleanse the right side of R4's buttocks. V10 did not remove her gloves when touching R4's skin and clothing. V9 then cleansed R4's right side of his buttocks. After incontinent care was completed V9, V10, and V11 all were touching R4's bed linens with their contaminated gloves. V2 (Director of Nursing/DON) was in the room observing and told V9, V10 and V11 that they need to take their gloves off when touching linens. V9 and V11 did get a new sheet after they removed gloves but never performed hand hygiene after removing gloves. On 01/15/25 at 2:52PM, V2 (DON) said that V10 should have changed her gloves after cleaning the stool and then washed her hands or used hand sanitizer before applying new gloves. V2 said that her staff usually does better incontinent care, but she hasn't has a chance to review with them in a while. V2 said that anytime the staff changes their gloves they should wash their hands or use hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/16/25 at 10:43 AM, V6 (CNA) said that all staff are to wash their hands prior to care of a resident. V6 said if they perform incontinent care, and they are cleaning up stool that they should take their gloves off and use hand sanitizer or wash hands before applying new gloves and then finish care. V6 said any time your gloves are soiled, or you are going from dirty to clean you should remove gloves wash hands or use sanitizer before applying new gloves. V6 said you shouldn't touch the resident or linens with dirty gloves either. On 01/16/25 at 2:52PM, V10 (CNA) said that any times you change your gloves that you should wash your hands or use hand sanitizer. V10 said that she knows she messed up when performing incontinent care on R4. V10 said she should have changed her gloves and either washed her hand or used hand sanitizer. V10 said that she knows that you can't touch a resident clothes or linens with dirty gloves either. The facility policy titled Handwashing undated documents in part The Center for Disease Control (CDC) introduced its 1985 guideline for handwashing with the statement that handwashing is the single most important procedure for preventing nosocomial infections. Indications for handwashing documents before and after touching wounds, whether surgical, traumatic, or associated with an invasive device, after situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes (including oral and vaginal surfaces) blood or body fluids, secretions, or excretions even when gloves are worn.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation, and record review the facility failed to follow standards of practice for antibiotic use for one (R3) of one resident reviewed for antibiotic use in a sample of 23. Findings include: R3's Admission Record documents an admitted [DATE] with diagnoses including: anxiety disorder, cerebral infarction, chronic kidney disease, gastro esophageal reflux disease without esophagitis, and adult failure to thrive. R3's Physician's Order sheet documents an order dated 01/08/25 for: z-pak r/t (relating to) bronchitis. The facility document dated Jan (January) 2025 titled, Infection Control Log (new form) documents: resident (R3), onset date: 01/08/25, date resolved: 01/13/25, infection related dx (diagnosis) respiratory, culture: the no column is checked, organism: with nothing listed, antibiotic: z-pack, isolated: with the column no checked, nosocomial: with the column yes checked. R3's nurse's notes dated: 12/23/24 (R3) has zero sign or symptoms of distress, zero signs or symptoms of covid, zero cough or congestion, zero nasal drainage, zero complaints of pain. (R3) is afebrile, with appetite fair, feeds self and has her call light within reach. R3's nurse's notes do not include any notes between 12/23/24 and 01/08/25. R3's nurse's notes dated 01/08/25 at 11:00 AM documents: doctor here, examined resident, reviewed medical records, discussed weight and diets. All questions answered. New orders, Z-pak ordered relating to bronchitis. R3's Care Plan does not contain a section for respiratory problems or concerns. R3's Extra Care Plan Sheets dated 11/10/24 document problem 2: phlegm: to decrease phlegm by 11/30/24 with approach listed as: Zyrtec 10 mg (milligrams) po dly (per oral daily) and increase fluids. On 01/15/24 at 2:12 PM, V2 (Director of Nursing) stated R3 had symptoms of clear phlegm on 11/10/24. On 12/27 the nurses note shows no cough on 12/27/24 which is the last note before he doctor come in on 01/08/24 when she received the antibiotic to what she remembers it was still clear phlegm. They pointed out the symptoms of R3's cough with clear phlegm and the fact that she would spit it into a tissue, sometimes with food into a tissue, it would just be a little of either most of the time, out to the doctor when he was making rounds and he gave her an antibiotic. She could go through three boxes of tissues a day. She still does. There was no culture done or x-ray done. He thought it might help. They should have charted for 72 hours after she received the antibiotic but they did not do that either. She will cough up clear phlegm and food and spit it out so the doctor gave her the antibiotic. On 11/14/24 at 12:10 PM, R3 was observed sitting in the dining room, she would take a bite of food and cough, she would spit it into a tissue and throw it away. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 at 12:15 PM, R3 was observed coughing up what appeared to be clear substance into a tissue and threw it away. The CDC (The Center for Disease Control and Prevention) website: https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit documents: Test and Treat: Develop plans to provide rapid clinical evaluation and intervention to ensure residents receive timely treatment and/or prophylaxis when indicated.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41610 Based on observation, interview, and record review the facility failed to provide a safe, sanitary, and clean home-like environment for the residents. This has the potential to affect all 24 residents residing at the facility. Findings including: On 01/13/24 at 12:53 PM, the shower room on the 200 hall had an accumulation of dirt and mildew along the edges between the floor and the wall in the caulk of all three walls of the shower stall. In this same room there is was accumulation of dirt on the floor in between the 1 inch by 1 inch tiles. There is an accumulation of dirt and debris along the edge of the bottom of the toilet where the toilet meets the floor. There was an approximate 2 millimeter black ring inside the toilet bowl. There was a large linen barrel and trash can blocking access to the hand washing sink. On 01/13/24 at 12:57 PM, in shower room on the 400 hall there was an accumulation of a black substance between the floor and wall on the left side of the shower stall and at the ridge between the shower stall and the bathroom floor. There are three 4 inch by 4 inch tiles missing along the wall of the shower stall. On 01/13/24 at 12:59 PM, in the hall bathroom on the 400 hall the toilet had an accumulation of dirt and debris along the base of the toilet in the caulk and areas where the caulk is missing. The bowl of the toilet had an approximate 3 millimeter black ring inside of it. Inside the shower stall there was a section of tiles missing of 3 inches by 3 inches and another section of tiles missing of 5 inches by 4 inches. There was an accumulation of items, a large linen barrel on a hand cart, a large trash can, and a wheelchair with leg rests laying in the seat of the chair blocking access to the handwashing sink. On 01/14/24 at 1:26 PM, R7's handwashing sink filled to the point of almost overflowing onto the floor in approximately 36 seconds and the sink drained in 8 minutes and 52 seconds. On 01/14/24 at 1:31 PM, R7 stated the sink takes a long time to drain. R7 stated, (while surveyor was timing the sink draining) you might not want to wait that long, it takes a long time (for the sink to drain). R7 stated, the sink has been that way for a while she has told them about it. R7 is alert and oriented to person, place, and time. On 01/15/24 at 12:42 PM, R6's room had an accumulation of spider webs around the heating unit in the area between the unit and the wall and along the floor. On 01/15/24 at 12:45 PM, the shower room on the 200 hall had an accumulation of dirt and mildew along the edges between the floor and the wall in the caulk of all three walls of the shower stall. In this same room there was an accumulation of dirt on the floor in between the 1 inch by 1 inch tiles. There was an accumulation of dirt and debris along the edge of the bottom of the toilet where the toilet meets the floor. There was a large linen barrel and trash can blocking access to the hand washing sink. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/15/24 at 12:49 PM, in the hall bathroom on the 400 hall the toilet had an accumulation of dirt and debris along the base of the toilet in the caulk and areas where the caulk is missing. Inside the shower stall there was a section of tiles missing of 3 inches by 3 inches and another section of tiles missing of 5 inches by 4 inches. There was an accumulation of items, a large linen barrel on a hand cart and a large trash can, and wheelchair with leg rests laying in the seat of the chair blocking access to the handwashing sink. On 01/14/25 at 3:00 PM, V13 (Housekeeping) stated the shower rooms on the 200 and the 400 halls are the only shower rooms. All the residents use those shower rooms. The residents on the 400 hall do not have toilets in their rooms so they have to use the ones on the hall but other residents will use the hall bathrooms sometimes also. On 01/16/25 at 2:20 PM, V13 (Housekeeping) stated the shower rooms always look like they have dirt and grime on the floors. She stated she doesn't clean the bathrooms that the other housekeeper does. She said they do consult with her if they can't get something clean. She said they do try to clean the floors, but they always look bad. She said the toilet always has the ring in it. She said they try to get rid of the ring in the toilet they have even tried some comet and that seemed to help. She said the bathrooms probably looks bad in the morning they don't usually clean them until later in the day. She said they have a lot of guys that go in the bathroom and throw stuff around and pee all over the floors all the time. She said that they don't have a housekeeper in the evening only the two on day shift. On 01/15/24 at 2:55 PM, V2 (Director of Nursing) stated, she does not know if they have an environmental cleaning policy, she will have to look if she can find one. The Long-Term Care Facility Application for Medicare and Medicaid form 671 dated 1/14/25 documents there are 24 residents living in the facility.