

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Manor Court of Clinton		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Park Lane West Clinton, IL 61727	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>50430</p> <p>Based on interview and record review the facility failed to ensure Resident Council grievances were resolved in a timely manner. This failure had the potential to affect all 90 residents who reside in facility.</p> <p>Findings include:</p> <p>The facilities Grievance Policy revised 6/1/2022 documents residents have the right to voice grievances to the facility and grievances shall be addressed by the facility in a timely manner.</p> <p>Resident Council Minutes dated 1/8/24 document under old business concerns with cell phone and ear bud usage, call lights not being answered timely, and certified nursing assistants (CNAs) are loud in hallways. Resident Council Minutes for 3/11/24 document under new business concerns with second shift CNAs on phones during meals and rude attitudes when answering call lights with what do you want. Resident Council Minutes dated 4/1/24 document phone usage during resident cares is still a concern. Resident Council Minutes dated 6/3/24 document CNAs are always on their phones. Resident Council Minutes dated 7/8/24 document CNAs are on their phones once managers leave. Resident Council Minutes dated 8/5/24 document concerns with CNAs being on cell phones and in evening they gather in the dining room and get on phones as soon as management leaves. Resident Council Minutes dated 9/9/24 document CNAs gathering in dining rooms on cell phones or electronic device. Resident Council Minutes dated 10/14/24 document CNAs are still on phones during cares. Resident Council Minutes dated 11/4/24 document residents are still having issues with nurse/ CNA on cell phones.</p> <p>On 12/03/24 at 10:25 AM, R16 stated we have been complaining about certified nursing assistants (CNA) at resident council meetings for months. R16 stated CNAs are talking on their phones and have ear buds in ears while providing care for residents. R16 further stated she does not feel the facility is addressing the problem.</p> <p>On 12/3/24 at 10:35 AM, R63 stated the CNAs are always on their phones once management leave the building. R63 stated they bring it up all the time, but it's not getting better.</p> <p>On 12/3/24 at 1:00 PM, V1 Administrator stated she is aware of the cell phone issues in the facility and the facility plans to implement management staying later in evening to monitor cell phone usage by staff.</p> <p>(continued on next page)</p>

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facilities roster dated 12/2/24 documents 90 residents reside in facility.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>37813</p> <p>Based on interview and record review the facility failed to submit the Minimum Data Set (MDS) in a timely manner for one resident (R74) of 18 residents reviewed for MDS in a sample list of 43.</p> <p>Findings Include:</p> <p>The facility's Final Validation Report printed 12/4/24 at 8:52AM documents R74's MDS target Date 5/2/24 Care Plan Late. Care Areas Assessment (CAA) is more than 13 days after entry date. R74's MDS target Date 7/24/24 Assessment completed Late. Care Areas Assessment (CAA) is more than 14 days after assessment reference date.</p> <p>On 12/04/24 at 8:56 AM V16 Care Plan Coordinator and V17, Corporate Care Plan Consultant verified Assessment/Care Plan for R74 dated 5/2/24 and 7/24/24 were late.</p> <p>The facility's Care Plan Policy revised 11/28/19 states The comprehensive Care Plan will be developed within seven days after the completion of the comprehensive MDS assessment as outlined in the resident assessment (RAI) guidelines.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49492</p> <p>Based on interview and record review, the facility failed to accurately complete resident comprehensive assessments. This failure affects one resident (R14) of 3 residents reviewed for accuracy of assessments on the sample list of 43.</p> <p>Findings include:</p> <p>R14's Minimum Data Set (MDS) dated [DATE] Section N0415 documents R14 as taking an anticoagulant.</p> <p>R14's Clinical Physician Orders do not document an order for an anticoagulant in the medical record.</p> <p>On 12/3/24 at 2:15 PM V16 stated R14 was not on an anticoagulant and the MDS was coded wrongly. V16 stated V16 would need to modify and submit a correct MDS.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49492</p> <p>Based on interview, and record review, the facility failed to refer residents with newly diagnosed serious mental disorders for a level II PASARR (Pre-Admission Screening and Resident Review) resident review upon a significant change in status assessment for two of two residents (R6, R14) reviewed for level II screening in the sample list of 43.</p> <p>Findings include:</p> <p>R6's Continuity of Care Document dated 12/04/2024 at 12:59 PM documents an admitted [DATE].</p> <p>R6's Interagency Certification of Screening Results dated 8/13/2020 does not document there is a reasonable basis to suspect a mental illness for R6.</p> <p>R6's Continuity of Care Document dated 12/04/2024 at 12:59 PM documents a diagnosis of Unspecified psychosis not due to a substance or known physiological condition was added for R6 on 04/04/2024.</p> <p>R6's Continuity of Care Document dated 12/04/2024 at 12:59 PM documents a physician order for the antipsychotic medication Seroquel (quetiapine) 25 mg tablet at bedtime.</p> <p>R14's Continuity of Care Document dated 12/04/2024 at 1:00 PM documents an admitted [DATE].</p> <p>R14's Interagency Certification of Screening Results dated 5/13/2020 does not document there is a reasonable basis to suspect a mental illness for R14.</p> <p>R14's Clinical Physician Order dated 09/15/2022 at 04:36 PM documents a diagnosis of Paranoid schizophrenia.</p> <p>R14's Clinical Physician Order dated 09/15/2022 at 04:36 PM documents a physician order for the antipsychotic medication Seroquel (quetiapine) tablet; 100 mg; twice daily.</p> <p>On 12/3/24 at 11:27 AM V2 Director of Nurses stated any resident with a mental illness should have a level II screening.</p> <p>On 12/3/24 at 12:45 PM V1 Administrator stated the social service director is responsible for screenings. V1 stated the two residents (R6, R14) do not have a level II screening in the medical record.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50322</p> <p>Based on observation, interview and record review, the facility failed to implement accurate complete care plans to include fall prevention, pressure ulcer prevention, oxygen treatment, communication methods and medications for four of four residents (R15, R40, R54, R231) reviewed for care plans in a sample list of 43.</p> <p>Findings Include:</p> <p>1.) R15's face sheet dated 12/04/24 documents medical diagnoses including Left Femur Fracture, Acute Kidney Failure, Pressure Ulcer of Buttock Stage 2, Major Depressive Disorder, and Anxiety.</p> <p>R15's Physician Wound Notes dated 10/23/24, 10/31/24, 11/6/24, 11/13/24, and 11/20/24 document unstageable, stage 4 and stage 3 pressure ulcers for R15.</p> <p>On 12/3/24 at 11:04 AM R15 had dressings to the right shin, left heel, and left great toe.</p> <p>R15's current Care Plan with admitted [DATE] does not document any pressure ulcers or current interventions.</p> <p>R15's Progress Note dated 8/15/2024 at 09:08PM documents R15 self-propelled into R15's room and placed the call light on and R15 was notified that the CNA (certified nurse assistant) was with another patient, and it wouldn't be long. The Progress Note documents R15 was heard yelling for help and R15 was found kneeling with R15's upper torso on the bed, in a praying type of position.</p> <p>R15's current Care Plan with admitted [DATE] does not include documentation on falls or fall interventions.</p> <p>R15's Hospital Discharge Records dated 10/4/24 document medication orders for Duloxetine (anti-depressant) 60 milligrams (mg) daily, Mirtazapine (anti-depressant/antianxiety) 15mg at bedtime, and Apixaban (anti-coagulant) 2.5mg daily.</p> <p>R15's Care Plan with admitted [DATE] does not document anti-coagulant or anti-depressant and anti-anxiety medication use nor interventions for nursing care.</p> <p>On 12/3/24 at 12:20 PM, V6 Registered Nurse (RN), stated R15 takes anti-coagulant and anti-depressant and anti-anxiety medications. V6 stated R15 does have multiple pressure ulcers and is unclear why his care plan does not reflect this. V6 stated R15 had fall on 8/15/24 and that R15 is impulsive and inpatient which is why he fell .</p> <p>2.) R231's face sheet dated 12/04/24 documents medical diagnoses including Heart Failure and Chronic Obstructive Pulmonary Disease with (acute) Exacerbation.</p> <p>On 12/02/24 at 11:00 AM R231 was resting in bed with oxygen running at three liters per minute via a nasal cannula and a portable oxygen tank was attached to a walker next to R231's bed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R231's current Care Plan dated with admitted [DATE] does not include an oxygen therapy plan of care.</p> <p>3.) R54's face sheet dated 12/04/24 documents an admitted [DATE] for Vascular Disorder of the Intestine.</p> <p>On 12/02/24 at 10:00 AM, R54 stated she is in the facility for rehabilitation following something happening in her stomach. R54 stated she experiences a great deal of pain from this. R54 stated she had been at the facility in the past about three years prior for therapy after a knee replacement.</p> <p>R54's Care Plan dated with admitted [DATE] documents R54 was admitted to the skilled nursing facility following recent hospitalization for left knee replacement. R54's Care Plan does not document any vascular disorder of intestine.</p> <p>37813</p> <p>4. On 12/02/24 at 2:18 PM R40 was in his room in a custom fitted wheelchair. R40 spoke very softly and deliberately but given time could be understood. R40 stated They don't take time to listen to me. They assume I can't talk to them, but I can. I have Amyotropic Lateral Sclerosis (Lou GehrigsDisease). I am 44 and I would like to be talked to. Sometimes I feel like I am not here.</p> <p>On 12/3/24 at 9:00AM V10, Licensed Practical Nurse (LPN) stated I am agency, but I come to this facility a lot. (R40) is alert and oriented and can speak, but not very loudly and it takes time to listen to (R40).</p> <p>R40's Care Plan updated 10/11/24 does not address R40's issue with effective communication.</p> <p>The facility's Care Plan Policy revised 6/1/22 states It is the policy of this facility to develop and implement a Base Line Care Plan, a comprehensive person-centered care plan and conduct care plan meetings as appropriate for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813</p> <p>Based on observation, interview and record review, the facility failed to revise care plans following falls with injury and new pressure ulcers for three of four residents (R26, R15, R181) reviewed for care plans in of a sample of 43.</p> <p>Findings Include:</p> <p>The facility's Care Plan Policy revised 6/1/22 states It is the policy of this facility to develop and implement a Base Line Care Plan, a comprehensive person-centered care plan and conduct care plan meetings as appropriate for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental, and psychological needs that are identified in the resident's comprehensive assessment.</p> <p>1. R181's Treatment Administration Record (TAR) for December 2024 includes a treatment order for Coccyx wound -apply calcium alginate and silicone bordered foam dressing daily.</p> <p>R181's Initial Wound Evaluation and Management Summary dated 11/27/24 documents (R181) has a stage II Pressure Ulcer on the coccyx measuring 1.2 x 0.7 x 0.1 Centimeters of greater that one days duration.</p> <p>R181's Care Plan reviewed 10/29/24 documents R181 is at risk for pressure ulcers but was not updated to include the current pressure ulcer.</p> <p>On 12/2/24 R181 was observed in bed. V34, R181's family member was visiting. R181 seemed confused and was oriented to person, but was disoriented to time and place. V34 stated R181 had a pressure ulcer on his coccyx for which he is now getting treatment. V34 stated (R181) has been confused since he came here after breaking his hip. R181 was not observed to be on a pressure relieving mattress. V34 stated (R181) is in bed a lot now. (R181) doesn't want to get up much.</p> <p>50322</p> <p>2.) On 12/3/24 at 11:04 AM, R15 stated he fell mid-September after he fell in August, causing refracture to R15's left femur head at the surgical site. R15 stated he returned to the hospital on 9/23/24 for left hip revision (surgery). R15 stated he returned to the facility October 4th, 2024.</p> <p>On 12/3/24 at 11:04 AM R15 was in bed without sheets and lying directly on the mattress. Dressings were present to R15's right shin and Left foot great toe and heel.</p> <p>R15's hospital discharge orders dated 10/4/24 documents orders for pressure ulcer treatment and post operative precautions.</p> <p>R15's current care plan with admitted [DATE] does not include documentation on falls or fall interventions. This care plan does not document revision surgery, or precautions needed post operatively. R15's care plan shows no documentation on pressure ulcers or preventative measures.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50430</p> <p>3.) R26's electronic medical chart documents R26 sustained unwitnessed falls with injury on 9/8/24, 9/18/24, and 10/13/24.</p> <p>R26's Progress Notes dated 9/8/24 at 5:56 AM, document R26 was found on the floor in R26's room bleeding from a laceration above the left eyebrow and bruising to the left eye. The Notes document R26 stated he dropped his toothbrush in the bathroom and was attempting to pick it up when he fell forward in the wheelchair and hit his head on the floor. The Notes document R26 was sent to the local emergency room where glue and adhesive strips were applied to a laceration above the left eye.</p> <p>R26's Progress Notes dated 9/18/24 at 7:15 PM, document R26 yelled for help and was found on the floor laying on his left side in between the recliner and the nightstand. The Notes document R26 stated he hit his head and R26 was sent to the local emergency room with left shoulder pain.</p> <p>R26's Progress Notes dated 10/13/24 at 3:25 PM, document R26 was found in his room lying beside R26's wheelchair with the wheelchair cushion on the ground. The Notes document R26 stated I don't know what happened. The Notes document R26 had one laceration on the top of his head measuring five centimeters in length, one laceration to the forehead measuring five centimeters in length, and a laceration to the right pinky finger measuring 0.5 centimeters in length. The Notes document R26 was sent to the local emergency room where five staples and seven sutures were applied to the lacerations on R26's head.</p> <p>R26's current care plan last revised on 9/17/2024 does not contain any fall interventions for R26's falls on 9/8/24, 9/18/24, and 10/13/24.</p> <p>On 12/04/24 at 09:52 AM, V20 Family Member stated R26 has had several falls. V20 stated it seems like R26 has fallen a lot and the staff say R26 is usually picking stuff up off the floor. V20 further stated V20 has been to care plan meetings at the facility but the facility has never discussed R26's falls or what they were going to do to prevent falls.</p> <p>On 12/4/24 at 1:59 PM, V2 Director of Nursing stated the floor nurse updates care plans after a fall with fall interventions and V2 audits care plans to ensure the interventions are there. V2 confirmed no fall interventions were initiated after R26's falls.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>37813</p> <p>Based on observation, interview and record review the facility failed to administer insulin per manufacturer's directions and according to standards of practice for three residents (R25,R45, R47) of four residents reviewed for insulin administration in a sample list of 43 residents.</p> <p>Findings Include:</p> <p>1. R25's Medication Administration Record (MAR) for December 2024 includes an active physician's order for Novolog (insulin) Flexpen U100. Subcutaneously per sliding scale before meals.</p> <p>The manufacturer's package insert for Novolog Flexpen U-100 documents Novolog starts acting fast. Eat a meal within 5 to 10 minutes after taking it.</p> <p>On 12/4/24 at 11:00AM V30 Licensed Practical Nurse (LPN) stated I have given all my insulin for 100 hall for lunch today. When asked when lunch would be served V30 stated about 12:00 Noon.</p> <p>R25's Medication Administration Record for December 2024 documents R25's insulin was administered at 11:04AM on 12/4/24.</p> <p>2. R45's Medication Administration Record (MAR) for December 2024 includes an active physician's order for Admelog SoloStar U-100 Insulin (insulin lispro)</p> <p>insulin pen; 100 unit/ml Amount to Administer: 16 units; subcutaneous with meals</p> <p>R45's Medication Administration Record for December 2024 documents R45's insulin was administered at 11:02AM on 12/4/24.</p> <p>3. R47's Medication Administration Record (MAR) for December 2024 includes an active physician's order for Admelog SoloStar U-100 Insulin (insulin lispro)</p> <p>100 unit/ml Administer per sliding scale before meals and at bedtime.</p> <p>R47's Medication Administration Record for December 2024 documents R47's insulin was administered at 11:02AM on 12/4/24.</p> <p>The manufacturer's package insert for Lispro insulin documents Administer Insulin Lispro by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal or immediately after a meal.</p> <p>On 12/4/24 at 12:10 PM V30 verified that lunch had not been served to R25, R45, R47 and R25, R45, R47 had not been given any nourishment between receiving insulin and being served lunch.</p> <p>On 12/5/24 at 9:00AM V1, Administrator verified lunch was served between 12:00PM and 12:05PM on 100 Hall on 12/4/24.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813</p> <p>Based on observation, interview and record review the facility failed to provide an effective communication program for one resident (R40) of 18 residents reviewed for communication in a sample list of 43.</p> <p>Findings Include:</p> <p>R40's Continuity of Care Document printed 12/5/24 includes the following diagnoses: Amyotropic Lateral Sclerosis, Dysphasia, and Anxiety Disorder.</p> <p>On 12/02/24 at 2:18 PM R40 was in his room in a custom fitted wheelchair. R40 spoke very softly and deliberately but given time could be understood. R40 stated They don't take time to listen to me. They assume I can't talk to them, but I can. I have Amyotropic Lateral Sclerosis (Lou Gehrig's Disease). I am 44 and I would like to be talked to. Sometimes I feel like I am not here.</p> <p>R40's Minimum Data Set (MDS) dated [DATE] documents R40 is cognitively intact and sometimes understood.</p> <p>On 12/3/24 at 9:00AM V10, Licensed Practical Nurse (LPN) stated I am agency, but I come to this facility a lot. (R40) is alert and oriented and can speak, but not very loudly and it takes time to listen to (R40). V10 verified there is no plan she is aware of to address R40's communication needs.</p> <p>R40's Care Plan updated 10/11/24 does not address R40's issue with effective communication.</p> <p>The facility's Care Plan Policy revised 6/1/22 states It is the policy of this facility to develop and implement a Base Line Care Plan, a comprehensive person-centered care plan and conduct care plan meetings as appropriate for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental, and psychological needs that are identified in the resident's comprehensive assessment.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>49492</p> <p>Failures at this level require more than one deficient practice statement.</p> <p>A. Based on interview and record review, the facility failed to transcribe and implement physician orders to start a medication for one of one resident (R72) reviewed for medication orders on the sample list of 41. This failure resulted in a delay of medication administration for R72.</p> <p>Findings include:</p> <p>R72 's Progress Note dated 11/14/2024 at 02:10 PM written by V41 Registered Nurse documents the primary care physician was at the facility. The Note documents a new order for Colace QD (Daily) for chronic constipation.</p> <p>On 12/5/24 at 10:43 AM, R72's Clinical Physician Orders do not contain the physician order to administer Colace (Laxative) daily.</p> <p>On 12/5/24 at 10:46 AM, R72's November 2024 Medication Administration Record does not document the administration of Colace.</p> <p>On 12/5/24 at 10:44 AM R72's December 2024 Medication Administration Record does not document the administration of Colace.</p> <p>As of 12/5/24 R72 has missed 21 doses of the medication.</p> <p>On 12/4/24 at 11:27 AM V2 Director of Nurses stated all nurses are to transcribe the physician orders as soon as the nurse's receive the order from the physician. V2 continued stating that V41 should have processed/transcribed the physician order and contacted the pharmacy as soon as the order was transcribed, and that R72's Clinical Physician Orders do not contain the ordered medication from the 11/14/24 progress note.</p> <p>50430</p> <p>B. Based on interview and record review the facility failed to complete neurological checks after unwitnessed falls with head injury for one of three residents (R26) reviewed for falls out of a sample list of 43.</p> <p>Findings include:</p> <p>The facilities Emergency Care Procedure policy revised 4/3/18 documents if a fall is unwitnessed, notify the physician and initiate neurological checks at least every 4 hours for twenty-four hours, or until stable, or as ordered by Medical Doctor.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R26's Electronic Progress Notes document on 9/8/24 at 5:56 AM, R26 had an unwitnessed fall in his room and was found on the floor with a laceration above the left eye. R26 was sent to the emergency room where they glued the laceration and applied adhesive strips to the laceration. R26's Electronic Progress Notes document on 9/18/24 at 7:15 PM, R26 had an unwitnessed fall in his room and was found on the floor laying on his left side. V26 Licensed Practical Nurse documents R26 stated he hit his head and had complaints of left shoulder and hip pain. R26 was sent to emergency room for evaluation and returned with bruising above the left eye and a skin tear above the right eye. R26's Electronic Progress Notes on 10/13/24 at 3:01 PM, document R26 was found lying on the floor next to his wheelchair. R26 had a laceration to the top of his head measuring five centimeters in length. V27 Licensed Practical Nurse documents R26 was sent to emergency room for evaluation. On 10/13/24 at 8:26 PM, notes by V28 Licensed Practical Nurse document, R26 returned to the facility with seven sutures and five staples to the forehead. Progress Notes and events from 9/8/24, 9/18/24 and 10/13/24 document no evidence of neurological checks were completed for R26.</p> <p>R26's Observation Assessments on 9/8/24, 9/18/24, and 10/13/24 do not contain documentation of neurological assessments.</p> <p>On 12/3/24 at 11:00 AM, V2 Director of Nursing stated the facility does not have documentation of neurological checks for any of R26's falls.</p> <p>On 12/03/24 12:23 PM, V6 Registered Nurse stated after a resident sustains an unwitnessed fall and hits their head, An Observation Assessment with neurological checks should be completed every four hours for twenty four hours.</p> <p>On 12/4/24 at 10:30 AM, V1 Administrator stated if a resident sustains a fall and hits their head neurological checks should be initiated and completed every four hours for twenty-four hours. V1 further stated the Director of Nursing should be auditing electronic medical records after an incident happens to ensure all documentation and assessments are being completed.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813</p> <p>Based on observation, Interview, and record review the facility failed to assess, implement interventions and physician ordered treatments to prevent the development/worsening of pressure ulcers for two (R181, R15) of three residents reviewed for pressure ulcers in a sample list of 43 residents</p> <p>Findings Include:</p> <p>1.) R181's Minimum Data Set (MDS) dated [DATE] documents R181 was cognitively intact and not at risk for pressure ulcers had any pressure ulcers.</p> <p>R181's Continuity of Care Document dated 12/5/24 includes the following diagnoses: Displaced Fracture Right Femur (10/30/24), Generalized Anxiety Disorder, Muscle Wasting/Atrophy, Parkinson's Disease, and Chronic Congestive Heart Failure.</p> <p>R181's Initial Wound Evaluation and Management Summary dated 11/27/24 documents (R181) has a stage II Pressure Ulcer on the coccyx measuring 1.2x0.7x0.1 Centimeters of greater than one days duration.</p> <p>R181's Treatment Administration Record (TAR) for December 2024 includes a treatment order for Coccyx wound -apply calcium alginate and silicone bordered foam dressing daily.</p> <p>On 12/2/24 R181 was observed in bed. V42, R181's family member was visiting. V42 stated R181 has a pressure ulcer on his coccyx for which he is now getting treatment. V42 stated (R181) has been confused since he came here after breaking his hip. R181 was not observed to be on a pressure relieving mattress. V42 stated (R181) is in bed a lot now. (R181) doesn't want to get up. much.</p> <p>The facility's policy Pressure Injury/Pressure Ulcer Prevention and Treatment revised 10/24/22 states: All high and moderate (Skin) risk residents will be assessed for the needs of the items below. If the intervention is needed it will be added to the Care Plan A. Special Mattress and Wheelchair Cushions.</p> <p>R181's Care Plan dated 10/29/24 documents R181 is at risk for pressure ulcers but was not updated to include the current pressure ulcer(11/27/24). There were no assessments for special need items nor changes in R181's skin risk status noted.</p> <p>50322</p> <p>2.) On 12/3/24 at 11:04 AM R15 observed in bed without sheets and resident lying directly on mattress. Dressing to right shin noted, undated, with black colored drainage in quarter size area on dressing. R15's left foot great toe and heel were wrapped in an undated dressings. R15's exposed feet were very dry and flaky white scales were noted on feet and mattress. Air mattress with bumpers noted. Error light flashing on air mattress however air mattress is inflated currently. R15 states he has pain in his left heel. R15's feet were in foam boots without socks noted. R15 states he has not gotten out of bed yet and wants to stay in bed now until family arrives at 2:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 2:15 PM on 12/03/24, R15 remained in bed in same position on right side as observed at 11:04 AM. At 3:25 PM R15 remained in same position, at this time R15 states he hasn't moved all day.</p> <p>R15's face sheet dated 12/04/24 documents medical diagnosis including fracture of unspecified part of neck of left femur with subsequent encounter for closed fracture and pressure ulcer of unspecified buttock stage 2.</p> <p>R15's hospital discharge orders dated 10/4/24 documents orders for pressure ulcer treatments for left heel wound, coccyx stage 2-3 pressure ulcer and left hip incision.</p> <p>R15's physician wound notes dated 10/23, 10/31, 11/6, 11/13, and 11/20/24 document unstageable, stage 4 and stage 3 pressure ulcerations.</p> <p>R15's facility treatment record dated 11/05/24-12/02/24 documents 13 missing treatment administrations.</p> <p>R15's current care plan with admitted [DATE] includes documentation on risk for skin breakdown but does not document any current pressure ulcers or current interventions.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430</p> <p>Based on interview, and record review the facility failed to complete a thorough investigation and implement/develop post fall interventions for three of three residents (R26, R16, R15) reviewed for falls in the sample list of 43. These failures resulted in R26 sustaining a fall requiring sutures and/or staples.</p> <p>Findings Include:</p> <p>1.) R26's electronic Progress Notes documents the following:</p> <p>9/8/24 at 5:56 AM, R26 had an unwitnessed fall in his room and was found on the floor with a laceration above the left eye. R26 was sent to emergency room where they glued the laceration and applied adhesive strips to the laceration.</p> <p>9/18/24 at 7:15 PM, R26 had an unwitnessed fall in his room and was found on the floor laying on his left side. This note by V26 Licensed Practical Nurse documents R26 stated he hit his head and had complaints of left shoulder and hip pain. R26 was sent to emergency room for evaluation and returned with bruising above the left eye and a skin tear above the right eye.</p> <p>10/13/24 at 3:01 PM, documents R26 was found lying on the floor next to his wheelchair. R26 had a laceration to the top of his head measuring five centimeters in length and was sent to the hospital for evaluation. Progress Note on 10/13/24 at 8:26 PM, document R26 returned to facility with seven sutures and five staples to his forehead.</p> <p>R26's current care plan last revised on 9/17/2024 does not contain any new fall interventions for R26's falls on 9/18/24 or 10/13/24.</p> <p>On 12/4/24 at 1:59 PM, V2 Director of Nursing stated the floor nurse updates care plans after a fall with fall interventions and V2 audits care plans to ensure the interventions are there. V2 confirms no fall interventions were initiated after R26's falls on 9/18/24 and 10/13/24.</p> <p>37813</p> <p>2.) R16's Continuity of Care Document printed 12/5/24 includes the following diagnoses: Difficulty Walking, Unsteadiness on Feet, Muscle Wasting/Atrophy.</p> <p>R16's Progress Note dated 11/22/2024 at 10:00AM documents (R16) observed in supine position on floor in hallway. (R16) reports that she lost her balance and fell forwards onto her right knee before positioning herself back onto her buttocks, then to supine position. (R16) denies hitting her head. Neurological signs Within Normal Limits. Range of Motion Within Normal Limits. x3 staff assist and full mechanical lift used to assist resident into bed. Resident voices complaints of pain to Right knee. 5cm x 2cm (centimeter laceration noted to right knee related to fall. Laceration cleansed and pressure applied. Resident sent to (hospital) related to right knee laceration.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R16's Progress Note dated 11/22/2024 at 1:20PM documents (R16) returned to facility at this time via Emergency Medical Services transport. Seven intact sutures noted to Right knee. Band-Aid noted to L arm r/t (related to) tdap (tetanus) injection. (R16) denies pain. New orders received for Keflex 500 mg (milligrams) BID (twice a day) x 10 days. New order received for Nurse to remove seven sutures in 10-14 days.</p> <p>R16's Care Plan updated 11/1/24 does not document any new interventions to address the 11/22/24 fall with injury. The facility did not provide documentation a thorough fall investigation was completed nor a root cause of the fall was identified for R16's fall on 11/22/24.</p> <p>On 12/4/24 at 2:15 PM, V2 Director of Nursing stated the floor nurse updates care plans after a fall with fall interventions and V2 audits care plans to ensure the interventions are there. V2 confirms no new fall interventions were initiated after R16's fall on 11/22/24.</p> <p>On 12/4 24 at 2:30PM V1, Administrator confirmed that a root cause analysis was not completed following (R16's) fall 11/22/24.</p> <p>50322</p> <p>3.) On 12/2/24 at 10:00 AM, R15 states he had a fall with aide involvement mid-September causing refracture to R15's left femur head at surgical site. R15 states he was impatient waiting for help with transferring and the aide and himself tumbled about 1 week prior to his surgery. R15 states he returned to hospital on 9/23/24 but surgery was delayed 2 days related to facility not holding blood thinner as ordered, then R15 found to have UTI delaying surgery longer.</p> <p>R15 progress note dated 8/15/2024 at 09:08 PM documents R15 self-propelled into room and placed call light on. R15 was notified that the CNA (certified nurse assistant) was with another patient, and it wouldn't be long. R15 heard resident yelling for help. R15 was found kneeling with upper torso on bed, in a praying type of position. MD (medical doctor) and POA (power of attorney) notified.</p> <p>R15's fall assessment dated [DATE] documents R15 care plan was reviewed, and all fall interventions were in place, but does not document new interventions post fall. R15's medical record does not document post fall assessments, fall risk assessments, neurological assessments, or frequent vital signs.</p> <p>R15's hospital records dated 9/23/24 document R15's orthopedic surgeon's physical as follows [AGE] year-old male who is non-ambulatory who had a [NAME]-cervical neck fracture and was doing well post-operatively until an aide fell on top of him. Since that time, he reports increased pain in the operative hip area and severe at times with transfers. He is non-ambulatory baseline. He is seen in the pre-op holding area this morning and his surgery has been canceled due to ongoing UTI along with his Eliquis being continued until Saturday. Past surgical history that includes Hip Fracture Surgery (Left, 6/13/2024).</p> <p>R15's hospital records dated 9/25/24 documents physician notes as follows: recent history of left femoral neck fracture status post closed reduction of intramedullary fixation of the left hip 06/13/2024. Complicated by traumatic displacement of the intramedullary nail. Hip x-ray from 09/20/2024 showed interval loosening/osseous fracture around the femoral head screw with inferior displacement of the femoral head.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/03/24 at 1:30 PM V6 RN states that R15 had to have revision surgery from hardware malfunction due to wrong hardware originally placed in R15 hip. Denies any incident where resident and staff member fell prior to revision. V6 does confirm R15 had a fall on 8/15/24 because R15 is impulse and inpatient.</p> <p>Facility failed to provide an investigation from 8/15/24 fall, on 12/3/24 at 2:15PM, V1 administrator, offered a nursing progress note dated 8/15/24. V1 denies knowledge of fall after 8/15/24 for R15 that included staff.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>49492</p> <p>Based on observation, interview and record review the facility failed to properly date, label humidifier bottles and oxygen tubing when changed for three of three residents (R11, R20, R231) reviewed for respiratory services in the sample list of 43.</p> <p>Findings include:</p> <p>The facility's Oxygen Policy and Procedure with a revision date of 03/16/17 documents, Oxygen set-up (cannula/mask, tubing) must be exchanged every 7days. Documentation: Date, time, flow rate, frequency, and results of oxygen therapy Medical Record.</p> <p>1.) R20's Medication Administration Record dated 12/1/2024 - 12/2/2024 documents O2 at 2 liters per nasal cannula continuous for SOB (Shortness of Breath). This Medication Administration Record dated 12/1/2024 - 12/2/2024 documents to Change O2 (oxygen(nebulizer tubing Q (every) week. This Medication Administration Record dated 12/1/2024 - 12/2/2024 documents V40 changed the tubing and humidifier bottle on 12/1/24.</p> <p>On 12/2/24 at 11:18 AM, R20's oxygen concentrator was running via a nasal cannula. There is no date of the humidifier bottle or tubing to indicate when it was changed and they are not stored in anything to protect from contamination. The humidifier bottle was empty.</p> <p>On 12/3/24 at 10:30 AM, R20 was in her room, eating breakfast wearing the nasal cannula from the oxygen concentrator. The nasal cannula and humidifier bottle remain undated. The humidifier bottle remains empty at this time.</p> <p>2.) R11's Clinical Physician Orders dated 12/3/24 documents O2 at 4 liters per nasal cannula PRN (as needed) for SOB (Shortness of Breath). The same Physician Orders document Change O2 (oxygen) tubing Q (every) week on Sunday night.</p> <p>On 12/2/24 at 10:08 AM, R11's oxygen concentrator was running via a nasal cannula. There is no date on tubing to indicate when it was changed and they are not stored in anything to protect from contamination. There was no humidifier bottle attached to the concentrator at this time.</p> <p>On 12/3/24 at 10:30 AM, R11 was not in her room, nasal cannula from the oxygen concentrator was laying on the bed. The nasal cannula undated. The continues to be no humidifier bottle attached to the oxygen concentrator at this time.</p> <p>On 12/3/24 at 11:27 V2 stated the nurses should be following the oxygen policy and that all nasal cannula tubing and humidifier bottles should be changed and dated weekly as ordered by the physician and the policy states.</p> <p>50322</p> <p>3.) R231's face sheet dated 12/04/24 documents medical diagnosis including heart failure and Chronic obstructive pulmonary disease with (acute) exacerbation.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/02/24 at 11:00 AM R231 resting in bed with nasal cannula in nose attached to oxygen tank on 3 liters concentrated oxygen per minute. Humidification bottle not bubbling, no date seen on humidification bottle. Oxygen tubing attached to patient does not have date visible. Portable oxygen tank with undated tubing attached to walker next to R231's bedside.</p> <p>On 12/04/24 at 10:45 AM R231 walking in hallway with therapy staff. Nasal cannula in nose attached to portable oxygen tank. No date noted on tubing.</p>		

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<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p>49492</p> <p>Based on interview, and record review, the facility failed to document receiving registry verification that the employee has met eligibility requirements to work in the facility prior to start date. This failure has the potential to affect all 90 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility census sheet dated 12/2/24 documents there are 90 residents who reside at the facility.</p> <p>On 12/3/24 at 10:00 AM employee V32 Certified Nursing Assistant (CNA), V33 CNA, V34 CNA, V35 CNA, V36 Cook, V37 Resident Aide employee files were reviewed for documented evidence of Illinois Health Care Worker registry eligibility to work in a healthcare facility. None was obtained from the employee files.</p> <p>Timecard reprint dated 12/3/24 at 11:47 AM documents V34 first day of employment was 11/20/23. Illinois Healthcare Worker Registry added to the employee file documents it was checked on 12/3/24.</p> <p>Timecard reprint dated 12/3/24 at 11:53 AM documents V33 first day of employment was 11/20/23. Illinois Healthcare Worker Registry added to the employee file documents it was checked on 12/3/24.</p> <p>Timecard reprint dated 12/3/24 at 12:24 PM documents V36 first day of employment was 11/21/23. Illinois Healthcare Worker Registry added to the employee file documents it was checked on 12/3/24.</p> <p>Timecard reprint dated 12/3/24 at 12:28 PM documents V32 first day of employment was 11/21/23. Illinois Healthcare Worker Registry added to the employee file documents it was checked on 12/3/24.</p> <p>Timecard reprint dated 12/3/24 at 12:29 PM documents V35 first day of employment was 11/20/23. Illinois Healthcare Worker Registry added to the employee file documents it was checked on 12/3/24.</p> <p>On 12/3/24 at 11:00 AM V13, Human Resource Manager, stated V13 was new to the human resources position. V13 stated V13 is unable to locate any documented evidence of registry verification for eligibility to work in the nursing facility for the new employees.</p> <p>On 12/3/24 at 11:12 AM V1 stated the human resource manager and staff are unable to locate documented evidence of registry verification for eligibility to work in the nursing facility for the new employees.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>37813</p> <p>Based on interview and record review the facility failed to monitor one resident (R38) receiving opioid medication for bowel function for one resident reviewed for opioid medication in a sample list of 43.</p> <p>Finding include:</p> <p>R38's Medication Administration Record (MAR) for December 2024 documents R38 has a current order for hydrocodone-acetaminophen tablet; 5-325 mg; amt: 1tablet; oral Every 8 Hours - PRN (as needed). It is documented on this MAR R38 received this as needed medication four times between 11/29/24 and 12/4/24.</p> <p>There is no documentation to support R38's bowel function is being monitored.</p> <p>R38's Care Plan reviewed 10/8/24 does not include interventions to monitor bowel movements for use of an opioid medication.</p> <p>R38's Progress Note dated 10/9/24 at 8:14 Am documents R38 reported (R38) had not had a bowel movement in three days</p> <p>On12/4/24 at 2:00PM V2, Director of Nursing verified the facility has no system in place for monitoring of bowel function in residents who use narcotic medications but if a resident doesn't have a bowel movement is a few days it would be charted in the Progress Notes.</p> <p>On 12/4/24 at 2:05PM V1, Administrator verified the facility does not have a policy specific to narcotic medication monitoring.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813</p> <p>Based on interview and record review the facility failed to obtain consent, assess/monitor residents receiving psychotropic medications and failed to document attempts to utilize nonpharmacological interventions for two residents (R15, R38) reviewed for psychotropic medication in a sample list of 43.</p> <p>Findings include:</p> <p>The facility's Pharmacological Drug Usage Procedure revised 10/18/17 states Purpose: 1. To provide appropriate assessment and monitoring of residents receiving these (psychotropic) medications. 2. To ensure residents receive gradual dosage reductions and behavioral interventions in an effort to discontinue these medications and minimize adverse consequences. Procedure: 2. Psychopharmacological medication usage must be reassessed at least every 90 days and include rationale for continuation the medication.</p> <p>1.) R38's active physician's orders printed 12/5/24 include the following orders for psychotropic medications Clonazepam (antianxiety) 1 mg (milligrams) TID (three times daily) Trazadone (Antidepressant) 50 mg daily, Paxil (Antidepressant) 20 mg daily and Melatonin (Sleep Aide) 5mg at bedtime daily.</p> <p>R38's electronic medical record does not include assessments for these Psychotropic medication. There is no documentation to support nonpharmacological interventions were attempted. There are no targeted resident specific behaviors identified or tracked for R38.</p> <p>On 12/4/24 at 2:30PM V2, Director of Nursing verified there are no psychotropic medication assessments, behavior tracking, or nonpharmacological interventions identified or tracked for R38. V2 also verified R38 is receiving the above list of psychotropic medications.</p> <p>50322</p> <p>2.) On 12/3/24 at 1:15 PM V6 registered nurse (RN) states there is no specific behavior tracking and that if resident has behavior out of the norm, then there would be a progress note. V6 states R15 has angry periods where he just cannot be redirected out of mood. R15 will often call POA (power of attorney) and that helps calm him down. V6 states they are attempting behavior modification with R15 but most times they go through the steps of redirection with R15, and it fails. V6 states the reasoning for the scheduled anti-anxiety medications is because POA wants R15 to be consistent with medications and behaviors even though resident is sleeper and more withdrawn.</p> <p>R15's point of care (POC) task tracking sheet dated 11/01/24 - 12/03/24 documents that certified nursing assistants (CNA's) only documented no behavior seen but does not document any specific behaviors, there were 27 entries out of the possible 99 documented. No behavior assessments documented in R15's medical record.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R15's hospital discharge records dated 10/4/24 document medication orders for duloxetine (anti-depressant) 60 milligrams (mg) daily, and mirtazapine (anti-depressant) 15mg at bedtime.</p> <p>R15's care plan with admitted [DATE] does not document anti-depressant and anti-anxiety medication use nor interventions for nursing care. There was no gradual dose reduction (GDR) attempted for R15's anti-depressants or anti-anxiety medications documented.</p> <p>On 12/04/24 at 10:15 AM, current lorazepam 1mg BID (twice a day) order consent requested from V2 and V2 provided old consent dated 7/25/24 for lorazepam 1mg prn (as needed) order. V2 states this is only consent on file.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430</p> <p>Based on interview and record review, the facility failed to ensure the timeliness of laboratory services were completed as ordered by a physician for one (R28) of one resident reviewed for laboratory services on the sample list of 43.</p> <p>Findings include:</p> <p>R28's undated face sheet documents a diagnosis of type two diabetes mellitus.</p> <p>R28's December 2024 Physician Orders documents and order for R28 to have an A1C (blood test to check ongoing sugar levels) was to be drawn on 2/3/24 and 8/3/24.</p> <p>R28's laboratory results dated [DATE] document results for an A1C level for 9/13/2023 and 10/16/24. R28's medical record did not contain any results for an A1C level on 2/3/24 and 8/3/24.</p> <p>On 12/4/24 at 1:00 PM, V31 Director of Therapy stated R28's A1C level has only been drawn once this year which was on 10/16/24. V31 stated they were unable to find labs for February 2024 and August 2024.</p> <p>On 12/4/24 at 1:30 PM, V2 Director of Nursing stated the floor nurses ensure the labs are being completed as ordered. V2 stated the only A1C level she can find for R28 this year was drawn on 10/16/24. V2 confirmed the labs were not obtained as ordered.</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813</p> <p>Based on interview and record review the facility failed to conduct and document an accurate facility assessment. This failure has the potential to affect all 90 residents who reside at the facility.</p> <p>Finding Include:</p> <p>The facility census sheet dated 12/2/24 documents there are 90 residents who reside at the facility.</p> <p>1. The facility assessment dated [DATE] Section A.1 states This facility has the following equipment to meet to meet the medical needs of the resident: Sit to stand or sling type mechanical lifts are not listed in this section.</p> <p>On 12/4/24 at 2:00PM V3, Assistant Director of Nursing provided a list of 18 residents who currently use mechanical lifts for mobility. V3 verified all of these residents use mechanical lifts for mobility. V3 verified it is possible that all residents who live at the facility could have to utilize a mechanical lift in the event of a fall.</p> <p>2. The facility assessment dated [DATE] Section B. Medications does not list Narcotic medications or opioids.</p> <p>R38's Medication Administration Record (MAR) for December 2024 documents R38 has a current order for hydrocodone-acetaminophen tablet; 5-325 mg (milligrams); amount: one tablet; oral Every 8 Hours - PRN (as needed).</p> <p>On 12/4/24 at 2:00PM V3 stated We do have orders for Narcotic pain medications for multiple residents at any given time.</p> <p>On 12/4/24 at 2:15 PM V1, Administrator verified the facility does utilize mechanical lifts and narcotic medication and these items are not included on the Facility Assessment.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>49492</p> <p>Provide and implement an infection prevention and control program.</p> <p>Failures at this level require more than one deficient practice statement.</p> <p>A. Based on observation, record review and interview, the facility failed to maintain infection prevention procedures to provide a sanitary laundry service. This failure has the potential to affect all 90 residents residing in the facility.</p> <p>Findings include:</p> <p>On 12/02/24 at 02:18 PM V9 identifies self as dayshift laundry aide. V9 entered the soiled linen holding room, applied gloves to the hands, no gown or other PPE (Personal Protective Equipment) was applied and sorted the soiled laundry into containers for personal linens, facility white linens, slings and facility incontinence linens. V9 removed the soiled linen from the collection barrels. Soiled linen included personal linen, soiled incontinence bed pads, soiled towels and washcloths, and soiled bed linen. V9 was observed leaning over soiled linen carts, V9's personal clothing was touching soiled linen collection barrels and the soiled linen including soiled bed pads, bed linens and soiled personal clothing. V9 states V9 sorts the laundry 3-4 times daily, is responsible for sorting, washing, drying and folding all laundry.</p> <p>On 12/02/24 at 02:25 PM V9 states she collects all soiled linen from the hallway collection barrels, sorts the soiled linen, then starts the soiled linen in the washing machines, transfers the clean linen from the washer to the dryer, removes clean linen from dryer to clean cart and fold the clean linen.</p> <p>On 12/02/24 at 02:28 PM V9 leans over the clean linen cart with the uniform touching the cart and moves the cart to the dryer and V9 then begins removing the clean linen from the dryer by reaching into the clothing dryer and placing the clean linen into the cart. Several pieces of clean linen, towels, sheets and wash cloths, touching V9 uniform as V9 pulled them from the clothing dryer closer to V9 for transfer to the clean linen cart. V9 states the clean towels, washcloths, and sheets are for use throughout the facility.</p> <p>On 12/02/24 02:32 PM V9 initiated a load of clothing protectors in the washer without washing V9's hands at this time.</p> <p>Inservice training record dated 5/14/24 provided by V8 document that V9 was trained on Job duties, dwell times, PPE (personal protective equipment) use, isolation and handwashing. V9 printed and signed the inservice training attendance sheet and confirms it is her signature.</p> <p>On 12/3/24 at 12:45 PM V1 stated that staff are expected to follow in-service training and all policies while working at the facility. V1 stated that V9 should have donned the proper PPE including a gown before sorting the soiled linen, doffed the PPE after completing the sorting of the linen and washed her hands.</p> <p>The facility census sheet dated 12/2/24 documents there are 90 residents who reside at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>B. Based on observation, interview, and record review the facility failed to notify visitors timely of a facility outbreak, failed to wear the appropriate personal protective equipment, and failed to prevent possible cross contamination for five (R54, R9, R70, R72, and R73) of five residents reviewed for infection control on the sample list of 43.</p> <p>Findings include:</p> <p>On 12/04/24 upon entering facility at 8:45 AM, observed V24 desk receptionist, V1 administrator, and V25 maintenance staff, wearing procedure masks. Facility entrance doors did not have any signage alerting to outbreak status or personal protective equipment needed to enter facility. V24 stated she was unclear if the facility had a Covid 19 outbreak stating, she was instructed to wear a mask.</p> <p>At 9:00 AM on 12/4/24, V1 stated there are 2 positive residents in facility on the 200 wing with Covid that were identified the evening prior on 12/3/24. V1 stated she had posted signage at entrance at 9:15 AM on 12/4/24.</p> <p>At 9:30 on 12/4/24, the following observations were made on the 200 wing:</p> <p>R54 has droplet and contact signage outside of room and PPE bin with N95 masks, gowns, and gloves available. Used N95 mask laying on top of PPE bin. Resident breakfast tray sitting on bedside table.</p> <p>R73 has signage of droplet and contact posted outside room with PPE bin including N95 masks. Breakfast tray noted on bedside table. V22, housekeeper, cleaning room with gown, gloves, and procedure mask, no eye protection on. V22 mopped floor and red bag removed from bin. V22 removed her gloves and gown outside of isolation room. V22's soiled gloves were used to close resident door, V22 then touched the dustpan on housekeeping cart.</p> <p>On 12/4/24 at 9:50 AM V23, dietary, states all isolation trays should be double bagged and then washed twice.</p> <p>At 9:54AM on 12/4/24, V15, Infection prevention licensed practical nurse, stated We are in outbreak status for two covid positive residents. All staff who enter the rooms should use N-95, gown, gloves, and hand hygiene. We are initiating contact tracing and testing. We will test all residents and staff. The Social Service Director is positive, but we have determined there was no contact with residents or staff. We are planning to reach out to local public health for guidance on testing in the future.</p> <p>Facility document titled Alert Media dated 12/4/24 documents text message sent to unknown staff at 3:51 PM on 12/3/24. Message states We have had a resident test positive for COVID. Going forward all staff will have to wear surgical masks until further notice. Proper PPE will be used when entering the affected residents room. Resident testing will start tomorrow. Staff testing information will follow shortly. Does not document who message was sent to or if message was received and understood.</p> <p>R73's progress note dated 12/4/24 at 3:04 PM documents covid positive test.</p> <p>R70's progress note dated 12/3/24 at 2:59 PM documents covid positive test.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R9's progress note dated 12/4/24 at 4:25 PM documents R9's readmission from hospital. This note documents on 12/1/24 at 12:26 PM when R9 was admitted to hospital, R9 tested positive for RSV.</p> <p>On 12/05/24 at 8:45 AM, three more residents identified with positive Covid tests. Immediate observation conducted on all facility wings. R9, R70 and R72 have droplet precaution signs on their room doors. R9 and R72 have isolation carts available, R70 did not have isolation cart.</p> <p>Observations were conducted on 12/4/24 between the hours of 9:30am to 3:30pm and 9:00am-11:00am on 12/5/24. During this time, facility staff were observed wearing standard procedure (surgical) masks throughout facility and in patient care areas. Direct care staff seen entering isolation rooms did not wear N-95 or equivalent masks and no eye protection was observed at any time. As of 12/5/24 the facility had no yet notified the local health department of facility outbreak.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49492</p> <p>Based on interview and record reviews, the facility failed to assess the residents for eligibility, and ensure residents were offered and administered the pneumococcal and influenza vaccines. This failure affects four (R14, R43, R26, R54) of five residents reviewed for immunization in the sample list of 43.</p> <p>Findings include:</p> <p>1. R14 Continuity of Care Document dated 12/04/2024 at 1:00 PM documents an admitted [DATE]. R14 medical record review does not include an Influenza Education and consent/declination form for the Influenza vaccine. R14 medical record contains an undated Pneumococcal Education and consent/declination form for the Pneumococcal vaccine. R14 face sheet dated 12/05/2024 at 10:02 AM documents administration of the Influenza Vaccine on 11/7/2023.</p> <p>R14 Medication Administration Record (MAR) dated 12/05/2024 at 10:03 AM for 10/1/24 thru 10/31/24 does not document the administration of the influenza/pneumococcal vaccines.</p> <p>2. R43 Face Sheet dated 12/04/2024 at 01:07 PM documents an admitted [DATE]. R43 medical record review contains an Influenza Education and consent/declination form for the Influenza vaccine that is completely filled out and dated 8/19/24 requesting the administration of the influenza vaccine. R43 medical record contains an undated Pneumococcal Education and consent/declination form for the Pneumococcal vaccine that is not filled out completely. The consent requests the administration of the Pneumococcal vaccine. R43 medical record contains an undated Covid-19 Education and consent/declination for the Covid-19 vaccine. R43 Face Sheet dated 12/04/2024 at 01:07 PM documents administration of the Influenza Vaccine on 11/8/2023, Pneumovax Date: declined 3/17/2020, and COVID-19 Vaccine: complete 1/5/21 & 1/28/21.</p> <p>R43 Medication Administration Record (MAR) dated 12/05/2024 at 10:09 AM for 10/1/24 thru 10/31/24 does not document the administration of the influenza/pneumococcal vaccines.</p> <p>3. R26 Face Sheet dated 12/04/2024 at 01:05 PM documents an admitted [DATE]. R26 medical record review contains an Influenza Education and consent/declination form for the Influenza vaccine that is completely filled out and dated 9/12/24 requesting the administration of the influenza vaccine. R26 medical record contains an undated Pneumococcal Education and consent/declination form for the Pneumococcal vaccine that is not filled out completely. The consent requests the administration of the Pneumococcal vaccine. R26 Face Sheet dated 12/04/2024 at 01:07 PM documents administration of the Influenza Vaccine on 11/10/2023 and a Pneumovax Date: **REF (Refused) 11/12/14.</p> <p>R26 Medication Administration Record (MAR) dated 12/05/2024 at 10:18 AM for 10/1/24 thru 10/31/24 does not document the administration of the influenza/pneumococcal vaccines.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. R54 Face Sheet dated 12/04/2024 at 01:01 PM documents an admitted [DATE]. R54 medical record review contains an Influenza Education and consent/declination form for the Influenza vaccine that is not completely filled out and dated 9/12/24 requesting the administration of the influenza vaccine. R54 medical record does not contain a Pneumococcal Education and consent/declination form for the Pneumococcal vaccine. R54 Face Sheet dated 12/04/2024 at 01:01 PM documents an administration of the Influenza Vaccine on 11/06/2023, and Pneumovax Date: 09/27/2016.</p> <p>R54 Medication Administration Record (MAR) dated 12/05/2024 at 10:26 AM for 10/1/24 thru 10/31/24 does not document the administration of the influenza/pneumococcal vaccines.</p> <p>On 12/3/24 at 11:35 AM V1 states if the consents are undated they are not valid, and there is no documentation of the vaccines being completed the vaccines have not been done.</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>49492</p> <p>Based on interview, and record review, the facility failed to document education, offering the COVID-19 Vaccine, and the consent and/or declination of COVID-19 vaccines for staff. This failure has the potential to affect all 90 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility census sheet dated 12/2/24 documents there are 90 residents who reside at the facility.</p> <p>On 12/3/24 at 10:00 AM employee V30 Licensed Practical Nurse (LPN), V32 Certified Nursing Assistant (CNA), V33 CNA, V34 CNA, V35 CNA, V36 CNA, V37 Resident Aide, V38 LPN, V40 LPN files were reviewed for documented evidence of education, offering of the COVID-19 Vaccine to staff, and the consent and/or declination of COVID-19 vaccines. None was obtained from the files.</p> <p>On 12/3/24 at 11:00 AM V13, Human Resource Manager, stated V13 was new to the human resources position. V13 stated V13 is unable to locate any documented evidence of education, offering of the COVID-19 Vaccine to staff, and the consent and/or declination of COVID-19 vaccines for staff.</p> <p>On 12/3/24 at 11:12 AM V1 stated the staff is unable to locate documented evidence of education, offering of the COVID-19 Vaccine to staff, and the consent and/or declination of COVID-19 vaccines for staff.</p>