STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146077	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Estates at Morris	1223 Edgewater Morris, IL 60450

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on interview and record review, the facility failed to order a residents chosen Advanced Directives status of DNR (Do Not Resuscitate). This applies to 1 of 1 resident (R268) reviewed for Advanced Directives in a sample of 28. Findings include: R268 admitted to the facility on [DATE], with diagnoses that includes encephalopathy, frontotemporal neurocognitive disorder, convulsions, type 2 diabetes, hypertension, anxiety, and dementia. On 10/10/24 at 3:16 PM, V25 (Family Member) stated R268 code status is DNR. V25 stated the code status was a part of the POA (Power of Attorney) paperwork that was provided to the facility. V25 stated R268 made the determination of her DNR status before she had cognition changes. V26 (Family Member) confirmed R268 made the decision for a DNR status some years prior to admission to the facility. On 10/09/24 at 3:49 PM, V2, DON (Director of Nursing), stated, All residents should have a code status on admission so the facility can adhere to the residents wishes of extending life versus not resuscitating. If a resident is admitted to the facility without a POLST (Physicians Order for Life Sustaining Treatment) or DNR, they are a full code. Without a POLST or physicians DNR order, it is assumed the resident is a full code. On 10/10/24 at 3:31 PM, V3, ADON (Assistant Director of Nursing), stated, Physicians orders are required for code status on admission. If her code status was apart of her POA, it should still be followed. R268's physician orders did not contain orders directing staff on resident resuscitation directives / code status. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R268's POA forms were scanned into the EMR (Electronic Medical Record). The POA for healthcare was signed and dated by R268 on Oct. 19, 2021. R268 wishes state the quality of my life is more important that the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings. I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and relieve my pain. The facilities undated policy Communication of Code Status states it is the policy of this facility to adhere to the resident's right to formulate Advanced Directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview, and record review, the facility failed to provide ADL (ADL/Activities of Daily Living) care to dependent residents. This applies to 2 of 2 residents (R307 and R356) reviewed for ADL care in the sample of 28. The findings include: 1. R307 was admitted to the facility on [DATE], with diagnoses of displaced transverse fracture of shaft of humerus, anxiety, muscle weakness, abnormalities of gait and mobility, polyneuropathy, depression, and arthritis. R307's MDS (MDS/Minimum Data Set), dated 09/06/24, showed R307 had moderate cognitive impairment. MDS task Section GG showed R307 required substantial/maximal assist to dependency with personal hygiene. R307's ADL Self-Care Performance Deficit care plan, initiated 04/21/24, showed R307 usually requires substantial- dependence for personal hygiene. Level of assistance may vary depending on resident's status. On 10/08/24 at 11:14 AM, R307 was in bed. R307's right eye had a crusted substance on the upper lid and the inner corner. On 10/09/24 at 2:22 PM, R307 continued to have a crusted substance to the upper eyelid and inner corner. R307 stated she wanted her face washed and the crust removed from her eye. On 10/10/24 at 12:21 PM, R307's right eye continued to have the crusted substance to the upper eyelid. R307 stated she had not had her face washed in a few days. R307 stated she wanted her face washed. On 10/10/24 at 12:31 PM, V17, (CNA/Certified Nursing Assistant), stated she had not washed R307's face today. V17 stated R307's eyes should not have a crusted substance. On 10/10/24 at 12:31 PM, V16 (CNA) stated she had not washed R307's face today. V16 stated R307 could get an eye infection if her face and eyes are not washed. V16 stated R307's face should have been washed when she woke up in the morning. On 10/10/24 at 12:34 PM, V22 (RN/Registered Nurse) stated R307 did not have an eye infection and is not receiving any eye drops or medications for an eye infection. V22 stated R307 does not have any drainage or redness to her eyes. On 10/10/24 at 3:13 PM, V2 (DON/Director of Nursing) stated, ADL's should be performed daily and every shift. Residents should have their faces washed every morning and when dirty. My expectation is that the CNA's accomplish ADL care every day. A visual assessment of the residents should be performed every day to see what they need. (R307) could get an eye infection if she has matter in her eyes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Activities of Daily Living (ADL's) Policy stated: Policy Explanation and Compliance Guidelines: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 46409 2. R356's face sheet showed R356 was admitted to the facility with diagnoses including Parkinson's disease with dyskinesia, pressure ulcer of right buttock and left buttock, weakness, repeated falls, chronic fatigue, and spinal stenosis. R356's MDS (Minimum Data Set), dated 9/10/24, showed R356 was dependent on staff for toileting hygiene and required substantial assistance from staff for personal hygiene. On 10/9/24 at 2:05 PM, V13 (CNA/Certified Nurse Assistant) went to R356's to assist him during toileting. V13 assisted R356 to a standing position and pulled R356's pull-up and pants up. V13 watched R356 pivot into the wheelchair and assisted him out of the bathroom. V13 did not wipe R356 after he had a bowel movement, and V13 did not offer to R356 to wash hands after using the bathroom. On 10/10/24 at 2:16 PM, V13 said she would encourage the resident to wipe themselves if they wanted to, but she would check because they could have not cleaned everything off. V13 also said she should help them wash their hands. On 10/10/24 at 2:11 PM, V16 (CNA) said after toileting a resident, she would assist with wiping themselves to make sure they got everything clean and use proper protocol. V16 said she would also assist them to wash their hands after toileting, since their hands would be contaminated from trying to wipe themselves. On 10/10/24 at 2:05 PM, V17 (CNA) said she would wipe the residents after they had wiped themselves to make sure they were cleaned well and as soon as the resident was done toileting, she would take them to the sink to wash their hands. On 10/10/24 at 2:40 PM, V2 (DON/Director of Nursing) said he expected the CNAs to wipe the residents after the resident had attempted to wipe themselves to make sure their hygiene was appropriate, since some residents did not have the coordination to wipe correctly. V2 also said the staff should encourage the residents to wash their hands to prevent them from spreading any potential contamination they may have on their hands. The facility's undated Activities of Daily Living (ADLs) policy showed A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 44387 Based on observation, interview, and record review, the facility failed to ensure anti-contracture devices and Controlled Ankle Movement (CAM) Boot were applied as ordered. This applies to 2 of 2 residents (R160 and R354) reviewed for assistive devices in a sample of 28. The findings include: 1. R160's Face Sheet shows diagnoses of Parkinsonism, weakness, and dementia. R160's Minimum Data Set of 10/17/24 shows R160's cognition is severely impaired. R160's Physician Order (POS) shows R160 has an order for hand rolls placed to reduce/risk of contractures every shift. R160's care plan, initiated 5/14/24, shows R160 has an Activities of Daily Living (ADL) self-care mobility performance deficit related to weakness, decreased mobility, with intervention to place handrolls in hands to reduce risk of contractures. On 10/8/24 at 11:52 AM, R160 was observed sitting in high back wheelchair in the dining room. R160's right hand was in fist form, arm folded on her abdomen. On 10/9/24 at 11:10 AM, R160 was sitting in her high back wheelchair in dining, with other resident; right hand still noted in fist form. On 10/10/24 at 12:14 PM, R160 was sitting in her high back wheelchair in dining room watching TV, right hand still noted in fist form, there was no splint in her hand. On 10/9/24 at 2:15 PM, V8 (Certified Nurse Aide/CNA) said R160 is not in any restorative program, they do not have restorative staff in facility. V8 said R160 has a carrot, that they use as a splint, and if it is dirty, she rolls up a washcloth and places it in R160's right hand. On 10/10/24 at 9:20 AM, V3 (Assistant Director of Nursing/ADON) said they do not have a restorative program for residents at the facility, and splints should be in place to prevent further contractures. The facility's Use of Assistive Device (no date) policy states it is the nurse's responsibility to monitor the resident for consistent use of the device and safety in the use of the device. 46409 2. R354's face sheet showed she was admitted to the facility with diagnoses including displaced bimalleolar fracture of right lower leg, muscle weakness, arthritis, abnormalities of gait and mobility, need for assistance with personal care, and cognitive communication deficit. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R354's POS (Physician Order Sheet) showed an order dated, 9/30/24: CAM boot can come off for ROM (Range of Motion) and stabilizing/exercise. On 10/8/24at 2:23 PM, R354 was lying in bed and a CAM (Controlled Ankle Motion) boot was on the resident's chair. R354 had signage in her room which showed CAM boot on at all times except bathing. On 10/9/24 at 2:17 PM, V14 (CNA/Certified Nurse Assistant) said R354 did not need to wear the CAM boot when she was in bed, only when she was in the chair. On 10/10/24 at 11:02 AM, V7 (CNA) said R354 only needed to wear the CAM boot when she was in the chair. V7 said she took care of R354 often, and when R354 was in bed, she did not need the CAM boot. On 10/10/24 at 1:59 PM, V20 (CNA) said he worked with R354, and her CAM boot was only supposed to be worn when R354 was in the wheelchair. On 10/10/24 at 2:28 PM, V21 (OT/Occupational Therapist) said R354 was non weight bearing to the right leg after a fracture on her right leg. V21 said when he had worked with her on 10/10/24 at 10:50 AM, R354 was in bed, and did not have the CAM boot on. V21 checked the POS (Physician Order Sheet) and said the CAM boot should not come off for anything other than range of motion and exercise, which were both activities done by therapy. V21 said the CAM boot should be on at all times, including when R354 was in bed. On 10/10/24at 2:40 PM, V2 (DON/Director of Nursing) said the orthopedic boot should be on at all times if there was an order for the boot to be on at all times, except during showers or wound care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to provide appropriate fall interventions and a hazard free environment to all residents. This applies to 4 residents (R207, R158, R360 and R261) reviewed for safe environment in a sample of 28. The findings include: 1. R207's Face Sheet shows he was admitted to facility on 8/15/23. R207's Face sheet shows a diagnosis of long term use of anticoagulants. R207's Morse Fall Scale Assessment performed on 9/19/24 shows he is high risk for falling. R207's Care Plan initiated on 10/7/24 shows resident has potential for and actual impairment to skin integrity of skin tear to right elbow related to history of falls. Care Plan initiated on 7/28/24 shows resident is at risk for falls. Interventions show resident needs a safe environment. The facility's Un-witnessed Fall Report, dated 10/7/24 at 8:00 AM, shows R207 was found lying on the floor next to his bed and reported to the nurse that he rolled out of bed and hit the floor and had pain on the right side of his head. The report shows R207 had a large bump on the right side of his head and large skin tear to his right arm. The report documents R207 is on blood thinner and hit his head, and 911 was called and resident was sent to the hospital. R207's Nurses Note, dated 10/7/24 at 1:36 PM, states resident fell out of bed this morning at 8 AM. He was sent out due to hitting his head and acquiring a hematoma on the right side of his head and large skin tear to his right arm. R207's Hospital CT Scan Report, dated 10/7/24, shows small right frontotemporal scalp hematoma. R207's Hospital Patient Visit Information, dated 10/7/24, shows resident was seen for closed head injury and Wound Care in Emergency Department. On 10/8/24 at 12:41 PM, R207 was observed with purple bruising and approximately 10 steri-strips on his right outer elbow and a purple bruise to his right forehead. R207 said he fell out of bed while reaching for a battery on the floor on 10/7/24, and he was sent to the hospital. R207 was not wearing non-skid socks and did not have any fall mats in his room. R207 said he had multiple falls since his admission to the facility. On 10/10/24 at 12:01 PM, multiple fall mats were observed piled up in a cubby in the hallway of R207's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 10:51 AM, V23 (RN/Registered Nurse) said she was working when R207 fell and hit his head on 10/7/24. V23 said R207's fall interventions include low bed, fall mat, call light within reach, and keep floor clear of clutter. V23 said there was no fall mat next to R207's bed when he fell on [DATE]. V23 said staff must have forgotten to put the fall mat back next to R207's bed. On 10/10/24 at 3:10 PM, V3 (ADON/Assistant Director of Nursing) said she is the lead of the QAPI (Quality Assurance and Performance Improvement) initiated fall prevention plan and their main focus for the year is reducing falls in the facility. V3 said she was aware of R207's fall on 10/7/24. V3 said R207's fall interventions include low bed, and new intervention added after R207's fall on 10/7/24 was provide a safe environment. V3 said R207 should have fall mats as a fall intervention because he is fragile, and she was not aware he did not already have fall mats in place. The facility's policy titled Fall Prevention Program, dated 10/3/24, states, Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls . Policy Explanation and Compliance Guidelines: . 8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed . 44387 2. R158's Face Sheet shows the following diagnoses of Need for assistance with personal care, history of falling and dementia. R158's Minimum Data Set (MDS) of 9/21/24 shows 7her cognition is severely impaired. R158's Care Plan (initiated 12/17/22) stated the resident is at risk for falls related to confusion, with interventions for bed to be low position at night, keep call lights and personal items within reach. R158 is not care planned for liking her bed high. R158's Fall Scale Assessment of 3/30/23 shows R158 is high risk for falls. R158's progress notes of 2/4/23 at 10:29 AM states R158 was found on her right side on the floor in her room, resident rolled out of bed. Progress notes of 7/23/24 at 1:28 AM, R158 was on the floor in her room, resident said she rolled out of bed, CNA was unable to keep her from hitting her head. On 10/8/24 at 10:52 AM, R158 called out for assistance. R158 was sitting up in bed watching TV; R158's bed was high, about surveyor's hip height (approximately 3 feet). R158 said she needs some assistance. Surveyor asked R158 to use her call light to alert staff. R158 pushed her call light at 10:53 AM. At 10:56 AM, V7 (Certified Nurse Aide/CNA) came in the room; R158 informed V7 her brief needed to be changed. V7 left the room to get supplies, left the bed high. V7 returned with supplies, and completed R158's incontinent care, readjusted R158 in bed, but did not lower the bed. On 10/9/24 at 10:54 AM, R158 is observed in bed sleeping, bed is high, about surveyor hip height. On 10/10/24 at 12:10 PM, R158 is sitting up in bed, finishing up her lunch. R158's bed is still high. R158 said she likes her bed low, then said no, she likes high. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 12:11 PM, V7 (Certified Nurse Aide/CNA) entered R158's room; V7 said she set up R158 for lunch, and R158 likes her bed that high. On 10/9/24 at 9:27 AM, V1 (Administrator) said R158 likes her bed high, and has not had any recent falls, her last fall was on 2/4/23. On 10/10/24, at 4:34 PM, surveyor asked V2 (Director of Nursing/DON) for R158's fall interventions, he said he was not familiar with her fall interventions. At 4:44 PM, V2 provided surveyor with R158's fall intervention care plans. 46409 3. R360's face sheet showed R360 was admitted with diagnoses including repeated falls, traumatic subdural hemorrhage, seizures, and osteoarthritis. R360's Morse Fall Scale. dated 2/3/24, showed R360 was at high risk for falls. R360's Care Plan, dated 2/10/24, showed R360 was at risk for falls [related to] recurrent falls which resulted in R360 being hospitalized in January 2024 for a subdural hematoma. She is a high fall risk related to generalized weakness, physical limitations, noted seizure activity, and decreased mobility, with interventions including to follow facility fall protocol. No interventions regarding fall mats were care planned for R360. On 10/8/24 at 11:51 AM, R360 was lying in bed. R360's bed was in the middle of the room, and she had one fall mat located on the left side of her bed. On 10/9/24 at 11:27 AM, R360 only had one fall mat on the left side of the bed. On 10/10/24 at 2:03 PM, R360 had one fall found on the left side of her bed. On 10/10/24 at 1:59 PM, V20 (CNA/Certified Nurse Assistant) said if a resident was at high risk for falls, there should be two fall mats in the room, one on each side if the resident's bed was not against the wall on either side. On 10/10/24 at 2:05 PM, V17 (CNA) said there should be fall mats on both sides of the bed. On 10/10/24 at 2:11 PM, V16 (CNA) said she would put fall mats on both sides of the resident's bed unless it was against the wall on one side. V16 said she was not sure why R360 only had one fall mat and there were extra fall mats in the facility. On 10/10/24 at 1:50 PM, V22 (RN/Registered Nurse) said the residents should have fall mats on both sides of the bed/ unless the bed was against the wall. On 10/10/24 at 12:19 PM, V3 (ADON/Assistant Director of Nursing) said the residents should have fall mats on both sides of the bed if the bed is not against the wall. V3 also said if the resident had fall mats in the room, they should be care planned for it. V3 said if there was an intervention put in place, the care plan should reflect the intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46003 4. R261 admitted to the facility on [DATE], with diagnoses that includes dementia, anxiety, insomnia and history of falling. R261's current care plan states R261 is at risk for falls related to confusion, deconditioning, gait / balance problems, history of falls, psychoactive drug use and unaware of safety needs. Interventions include the resident needs a safe environment and anticipation of resident's needs. The current MDS (Minimum Data Set) indicates R261 does not utilize any devices for mobility. On 10/08/24 at 10:42 AM, R261 was lying in bed. The left side of the bed was pushed against the wall under the window. The entire right side of the bed where R261 would exit had approximately 3 to 4 inches of the metal bed frame exposed. On 10/10/24 at 3:31 PM, V3, ADON (Assistant Director of Nursing), stated, Metal bed frames should not be exposed because a resident could be injured if the lay or fall on it. A resident lying in bed shouldn't have the frame exposed because could get caught on it.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on observation, interview, and record review, the facility failed to keep the indwelling catheter bag below the bladder level to prevent potential urinary tract infection (UTI). This applies to 1 of 2 residents (R57) reviewed for catheter care and treatment in a sample of 28. The Findings Includes: R57 is a [AGE] year-old male with severe cognitive impairment, as per the Minimum Data Set (MDS) dated [DATE]. R57 was admitted with an admitting diagnosis including urinary retention. On 10/8/24 at 11:00 AM, R57 was observed in his wheelchair with an indwelling catheter bag hanging behind his wheelchair and above his bladder level, with urine pooling in the catheter tubing. On 10/8/24 at 11:05 AM, V5 (Registered Nurse/RN) stated the therapist might be the one who left the indwelling catheter bag above bladder level. V5 also stated if the catheter bag is kept above bladder level, it can cause UTI. On 10/9/24 at 9:45 AM, V2 (Director of Nursing) stated the indwelling catheter bag should be below the bladder level, otherwise it could cause potential UTI. A review of the facility's Indwelling Catheter Use and Removal policy, dated 2023, documents: Secure the catheter to facilitate the flow of urine, prevent kinks in the tubing, and position it below the level of the bladder.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on observation, interview, and record review, the facility failed to follow their policy on maintaining a Peripherally Inserted Central Catheter (PICC) line. This applies to 1 of 1 resident (R62) reviewed for central line catheter care in a sample of 28. The Findings Includes: R62 is a [AGE] year-old male with cognition intact, as per the Minimum Data Set (MDS) dated [DATE]. R62 was admitted with a diagnosis of Sepsis, Right Lower Limb Cellulitis, and Osteolysis. On 10/08/24 at 10:42 AM, R62 was sitting on his chair with a left upper arm double lumen PICC line, with a dirty reinforced dressing, with no date or label, and was peeling off from the insertion site: On 10/08/24 at 10:42 AM, R62 stated he was not sure the facility had ever changed his PICC line dressing. Reviewing R62's Physician Order Sheet (POS) on 10/8/24 indicates no order to change R62's PICC line. On 10/08/24 at 11:20 AM, V5 (Registered Nurse/RN) stated there should have been an order to change the PICC line dressing. If the order were there, it would have been reflected in the Medication Administration Record (MAR) to change the PICC line dressing. V5 also added there was no documentation in MAR to prove staff changed the PICC line dressing every week. On 10/9/24 at 9:45 AM, V2 (Director of Nursing/DON) stated, The PICC line dressing changes are typically done weekly and as needed (PRN). The dressing should have been dated and labeled and that a dressing change order should be in place. If the dressing is not intact, it can cause central line-associated bloodstream infection (CLABSI). The facility presented PICC/Midline/Central Venous Access Device (CVAD) Dressing Change policy, reviewed /revised 10/1/24, documents: It is the policy of the facility to change PICC, midline or CVAD dressing weekly or, if soiled, in a manner to decrease the potential for infection and /or cross-contamination. Physician's orders will specify the type of dressing and frequency of changes.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on interview and record review, the facility failed to obtain consents for psychotropic/antidepressant medications, and failed to follow pharmacy recommendations. This applies to 2 of 4 residents (R156 and R308) reviewed for unnecessary medications in a sample of 28. The findings include: 1. R308 was admitted to the facility on [DATE]. R308 had multiple diagnoses which included myalgic encephalomyelitis/chronic fatigue syndrome, major depressive disorder, anxiety, sleepwalking, and abnormalities of gait and mobility. R308's MDS (MDS/Minimum Data Set), dated 08/05/24, showed R308 had moderate cognitive impairment. The same MDS Section N showed R308 was taking an antianxiety and an antidepressant. R308's Psychotropic medication use for depression and anxiety showed R308 was taking Clonazepam and Mirtazapine. R308's active Order Summary Report, dated 10/10/24, showed R308 had current and active orders for: Clonazepam 0.5 mg two times per day for anxiety, started 07/18/24; and Mirtazapine 45 mg at bedtime for mood, started 01/17/24. R308 did not have signed consents in the EMR (EMR/Electronic Medical Record) for either medication. There were no progress notes that showed a verbal consent for the medications. R308's MAR (MAR/Medication Administration Record) for October 2024 showed the nurses administered Clonazepam 0.5 mg two times per day and Mirtazapine 45 mg at bedtime to R308. On 10/10/24 at 3:03 PM V1 (Administrator) stated there were no signed consents for Mirtazapine or Clonazepam. V1 stated, I do not see a verbal consent documented in the medical record that we have consent to give the medications. We normally call the family to get a verbal consent, they sign it when they come in. Psychotropic medications should not be given until we receive a consent. On 10/10/24 at 3:13 PM, V2 (DON/Director of Nursing) stated, Without consent from the POA (POA/Power of Attorney), the resident can become over sedated. There is a potential for an adverse reaction. Consent forms should be signed before starting the medication. AIMS (AIMS/Abnormal Involuntary Movement Scale) should be done every six months for anyone on antipsychotics. If they are not completed, we might miss some of the tremors that are associated with psychotropic medications. It affects their dentation as well. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Use of Psychotropic Medication Policy stated: Policy Explanation and Compliance Guidelines: 3. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team. 5. Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. 8. Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, PRN (as needed) or as per facility policy. 44387 2. R156's Face Sheet shows the following diagnoses Alzheimer's Disease, mild cognitive impairment, depression, unspecified psychosis, and unspecified severe dementia. R156's Physician Order shows the following orders for Escitalopram Oxalate 20 mg, give 1 tablet by mouth one time a day for depression and Olanzapine 2.5 mg give 1 tablet by mouth at bedtime for psychotic disorder. R156's Pharmacist's Medication Regimen Review completed on 8/2/24 recommended to complete DISCUS AIMS (Dyskinesia Identification Scale/Abnormal Involuntary Movement Scale) test to be performed and repeated every 6 months while resident continues to receive antipsychotic medications. On 10/10/24 at 4:56 PM, V4 (Infection Preventionist/IP) presented the AIMS test for R156. The facility completed the AIMS test during the survey on 10/10/24 at 4:51PM. At 5:11 PM, V4 said they do not have medication consent for Escitalopram and Olanzapine; she said there should be a consent in place prior to administering the medications. On 10/10/24 at 5:00 PM, V3 (Assistant Director of Nursing/ADON) said AIMS test should be completed within a day of the pharmacy recommendations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview, and record review, the facility failed to label, store and dispose of medications to facilitate a safe administration to residents and avoid possible diversion of controlled substances; failed to assure medications, wound cleansers, and skin antiseptics / disinfectants were not accessible to residents; failed to dispose of expired medical supplies stored in the medication room; and failed to keep the medication room refrigerators free of excess ice buildup and maintain up to date temperature logs of medication room refrigerators. This applies to 7 residents (R60, R155, R206, R254, R259, R266 and R269) reviewed for safe medication storage in a sample of 28, and has the potential to affect all residents residing on the second floor. Findings include: On 10/10/24 at 2:14 PM, the second floor C/D medication cart was reviewed with V24, LPN (Licensed Practical Nurse). 1. A Aspart insulin pen labeled for R 269 was opened on 8/11, and expired on 9/9/24. R269's current physician's orders includes Aspart insulin sliding scale every morning and at bedtime for diabetes. V24, LPN, stated R269 still had a current physician order for Aspart insulin. V24 stated the pen should have been discarded when it expired. 2. A Glargine insulin pen labeled for R155 was accessed, and did not have an opened on or use by date written on it. R155 current physician's order includes Glargine 38 units in the morning for diabetes mellitus. V24, LPN, stated insulin pens are good for 30 days after they are opened, but there is not way to know when the pen expired if there are no opened on or use by dates written on it. 3. A Glargine insulin pen labeled for R254 was accessed, and did not have an opened on or use by date written on it. R254 current physician's orders includes Glargine 29 units daily for diabetes mellitus. On 10/10/24 at 11:40 AM, the narcotic count was conducted with V24, LPN. 4. The clonazepam 0.5MG (Milligrams) medication card for R266 count was 25 remaining tablets, with three of the blister packs taped. R266's current physician's orders includes clonazepam 0.5 MG one tablet two times a day for anxiety. V24 stated,The packs should not have been taped because the medication could have been contaminated. The medication should have been wasted. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The hydrocodone and acetaminophen 5/325 medication card for R259 count was 25 remaining tablets, with eight blister packs taped. There is no current physician's order in place for R259 to have hydrocodone and acetaminophen 5/325. The last administered dose documented on the controlled drug form for hydrocodone and acetaminophen 5/325 was on 3/27/24, after which D/C (discontinue) was written. V24 stated the medication was discontinued and should have been given to the supervisor for destruction. On 10/10/24 at 11:52 AM, the second-floor medication room was inspected with V24, LPN. The medication refrigerator freezer was filled with ice and did not have a temperature log. The medication refrigerator identified by V24 as the beer freezer section was filled with ice. The thermometer temperature reading was 32 degrees. The temperatures were logged for 10/1-10/8 with documented temperature readings of 36 each day and initialed MS. V24, LPN, stated the refrigerators need to be defrosted, but she did not know who was responsible for defrosting or logging the temperatures. Additionally, the following was observed: Seven universal catheterization trays expired on 12/31/22. Three IV (Intravenous) administration set tubing expired on 7/9/2023. Three IV administration set tubing expired on 7/4/2023. One iv administration set tubing expired on 10/6/2024. One urinary catheter tubing 14 fr (French) expired on 3/28/24. One urinary catheter tubing 14 fr expired on 7/28/24. Two urinary catheters tubing 18 fr expired on 4/28/24. V24, LPN, stated she didn't realize medical supplies had expiration dates on them. On 10/10/24 at 1:11 PM, the A unit cart inspection was begun with V2, DON (Director of Nursing). An Aspart insulin pen that had been accessed did not have a resident's name and opened on 8/10/24. V2 stated, Insulin pens expire 28 days after being opened. The product should not be used after the expiration date because it is less effective. The insulin should have a label, so you know who it belongs to and there is no cross contamination, but it uses a replaceable needle. When V2 was asked to explain what he meant by it uses a replaceable needle and should the expired insulin pen be stored in the cart, V2 refused to answer any further questions. V2 asked to ask the Administrator to come and observe further questioning for his comfort, and V2 refused. V2 stated the surveyor was attempting to ask tricky questions. V2 was asked if he should know what the expectations were for his nursing staff, V2 locked the medication cart and stated the surveyor would have to review the cart with the floor nurse and walked away. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 1:31 PM, V1, Administrator, stated insulin pens should be labeled with resident's name and dates, so they aren't used for the wrong resident. On 10/10/24 at 2:14 PM, the A unit medication cart was reviewed with V23, RN (Registered Nurse). Two packages of Diltiazem ER 120 MG were expired on 7/27/24 and did not have a patient's name. One green blister pack with cephalexin handwritten did not have a resident name on it or expiration date. Two packs of Pantoprazole sodium delayed release oral suspension did not have a resident's name on it. V23 RN stated it looks as if someone pulled them form the pyxis and left them in the cart. 6. An accessed Lispro insulin pen labeled for R206 did not have an opened on or use by date one it. An accessed Glargine insulin pen did not have an opened on or used by date and was in a bag of insulin pens belonging to another resident that was not on Glargine insulin. R206 has current physician orders for Lispro 5 units with meals for diabetes mellitus and sliding scale every morning and at bedtime for diabetes mellitus as well s Glargine 40 units at bedtime for diabetes mellitus. 7. An insulin Aspart pen belonging to R60 was opened on 8/10. No expiration date was written on the pen. R60's current physician order includes Aspart insulin sliding scale. On 10/10/24 at 3:31 PM, V3, ADON (Assistant Director of Nursing), stated, The night shift nurses should be logging medication room temperatures and keeping them defrosted. Ice build up throws off the temperature. Expired medications should be thrown out and no unlabeled medications should be stored in the medication carts. All personal use mediations should have the residents name on it, so it is not used on the wrong resident. Narcotics should not be taped, they can be contaminated and should be wasted by two nurses. The med can't be verified it is the same medication if it has been taped. Medications should not be used after they expire because the potency is diminished. Medical supplies should not be used after they expire because they could have germs. The rubber in urinary catheters can break down and should not be used. The undated facility policy Medication Storage states all drugs and biologicals will be stored in locked compartment under proper temperature controls. Refrigerated products are maintained within 36-46 degrees Fahrenheit. Charts kept on each refrigerator and recorded daily by charge nurse or designee. All medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated defective or deteriorated medications with worn illegible or missing labels. These medications are destroyed in accordance with the destruction of unused drugs policy. The facility undated Controlled Substance Administration and Accountability policy states nonstock drugs are returned to the pharmacy when no longer needed for the patient whose name they were issued as per state or pharmacy regulation. If the package has been opened or the tamper seal removed, it must be destroyed. The facility undated Insulin Pen policy states, insulin pens must be clearly labeled with the resident ' s name, physicians name, date dispensed, type of insulin, amount to be given, frequency and expiration date. If the label is missing, the pen will not be used: a new pen must be ordered from the pharmacy. Insulin pens should be disposed of after 28 days or according to the manufacture ' s recommendation. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46409 8. R357 was admitted to the facility with diagnoses including enterocolitis due to clostridium difficile, urinary tract infection, adult failure to thrive, obesity, lymphedema, type 2 diabetes mellitus, depression, and osteoarthritis. R357's POS (Physician Order Sheet) did not have orders for Zycam nasal spray, Vicks [NAME] Severe nasal spray and Hemp [NAME] Maximum Strength pain relief plus hemp cream. R357's POS did not have any orders for R357 to have medications at the bedside. The EMR (Electronic Medical Record) did not have a Safety Assessment to show R357 was safe to store medications at bedside. On 10/8/24 at 12:10 PM, during the general tour of the facility, R357 was observed to have several medications at bedside, including two bottles of Zycam nasal spray, two bottles of Vicks [NAME] Severe nasal spray and Hemp [NAME] Maximum Strength pain relief plus hemp cream. While the surveyor was in the room, R357 threw away an empty bottle of Zycam nasal spray and an empty bottle of Vicks [NAME] Severe nasal spray. R357 asked if she was not supposed to have medications at the bedside. On 10/10/24 at 2:40 PM, V2 (DON/Director of Nursing) said residents needed to have orders to keep medications at their bedside. V2 said they would notify the physician for an order and a safety assessment would be needed to make sure they were able to administer their medications appropriately. V2 also said the resident's medications should be kept in a drawer as other residents could get to it. 9. R359 was admitted to the facility with diagnoses including dementia, pneumonia, obesity, and polyarthritis. R359's POS showed an order for Nystatin external powder 100,000 units per gram, not cream, and did not have any orders for R359 to have medications at the bedside. The EMR did not have a Safety Assessment to show R359 was safe to store medications at bedside. On 10/8/24 at 11:34 AM, R359's room had a tube of Nystatin Cream 100,000 units per gram sitting on the dressing table. The medication did not have any prescription sticker on the tube of cream. 34410 10. R63 is a [AGE] year-old female with mild cognitive impairment as per the Minimum Data Set (MDS) dated [DATE]. On 10/08/24 at 10:35 AM, a half-full 60-gram Nystatin topical powder bottle (used to treat fungal or yeast skin infections) was observed at R63's bedside. 11. R64 is a [AGE] year-old female with cognition intact as per the MDS, dated [DATE]. On 10/08/24 at 10:38 AM, R64 was observed in her bed with a wound cleanser bottle (3/4th of a 16-ounce bottle, used to clean wounds), Hibiclens (3/4th of an 8-ounce bottle, used as an antimicrobial skin cleanser), and Betadine (half of an 8-ounce bottle, used to prevent infection and promote healing in skin wounds, pressure sores, or surgical incisions) at her bedside. On 10/09/24, at 9:45 AM, V2 (Director of Nursing / DON) stated the Nystatin, Hibiclens, Betadine, wound cleanser, etc., at the bedside should have been stored in the treatment cart. V2 added if the staff doesn't follow this guideline, the residents may likely ingest those. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility presented Medication Storage policy, revised 10/01/24, documents: All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature control. 48526 12. R304 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, urinary tract infection, chronic respiratory failure with hypoxia, allergic rhinitis, and need for assistance with personal care. R304's MDS, dated [DATE], showed R304 was cognitively intact. R304's Order Summary Report dated 10/10/24 showed active and current orders for Fluticasone Propionate Nasal Suspension 50 mcg/act one spray in both nostrils one time a day for allergies; and Hydrocortisone External Cream 1% apply to labia topically every 12 hours as needed for labia itching. R304 did not have an assessment or care plan to self-administer medications. On 10/08/24 at 10:27 AM, R304 had a bottle of Fluticasone nasal spray and a tube of Vagisil Cream in a basket, on the bedside table. On 10/09/24 at 2:10 PM, the Fluticasone nasal spray and the Vagisil cream remained in the basket on the bedside table. R304 stated she uses the Fluticasone nasal spray every day and keeps it in her room. R304 stated the nurses do not watch her while she takes the medication, or ask if she has taken it. R304 stated she uses the Vagisil cream as needed when she is experiencing vaginal itching. R304 stated she keeps the Vagisil cream herself and does not inform the nurses when she uses it. On 10/10/24 at 12:25 PM, R304 stated she had vaginal itching this morning and she applied the Vagisil cream that was in the basket on the bedside table. R304 stated she did not inform the nurse that she applied the cream this morning. On 10/10/24 at 12:06 PM, V4 (Infection Preventionist/RN) stated she was the nurse for R304 today. V4 stated R304 has active orders for Fluticasone nasal spray and hydrocortisone external cream. V4 stated she gave R304 the nasal spray this morning from the medication cart. V4 stated she did not know R304 had the medications stored in her room, or was taking them on her own. V4 stated R304 should not have had the Vagisil and Fluticasone in her room. V4 stated R304 had not been assessed to self-administer medications. V4 stated R304 could under or over medicate herself if she takes medications on her own. V4 stated she had no knowledge of R304 administering the vaginal cream today. V4 stated all medications should be stored and locked in the medication cart and not in residents rooms. On 10/10/24 at 12:54 PM, V2 stated Hydrocortisone and Vagisil share the same components. Both medications are interchangeable.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 45906 Based on interview and record review, the facility failed to employ sufficient staff to carry out the functions of the Food and Nutrition Services, including meal preparation. This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen. Findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671), dated 10/8/24, documents the total census was 90 residents. On 10/8/24 at 10:58 AM, V9 (Dietary Manager) said all residents eat from the facility kitchen; there are no NPO (Nothing by Mouth) residents. On Wednesday 10/8/24 at 11:45 AM, R205 said on the previous Monday they were supposed to have tuna salad on toast, but it was not served on toast, it was just white bread. On 10/10/24 at 11:27 AM, R205 said there had been multiple occasions when the meals served did not match the menu, and that made R205 feel like her ability to choose had been taken away from her. On 10/8/24 at 10:27 AM, V9 said the facility does not have sufficient Dietary staff. On 10/8/24 at 10:58 AM, V9 (Dietary Manager) said she switched the meals this week on Monday and Wednesday because they were short staffed on Monday. V9 said the Monday lunch meal was supposed to be chicken enchiladas, but chicken enchiladas have a long preparation time, and she only had 2 staff in the kitchen, herself and the cook. V9 said she is supposed to have at least 4 staff in the kitchen not including herself, the Dietary Manager. V9 said they should always be staffed with 1 Cook, 3 Dietary Aides, and 1 Dietary Manager. V9 said because she did not have enough staff on Monday, she prepared Wednesday's lunch on Monday, which was pulled pork, pasta salad, and pea salad. V9 said she does not want the resident's to suffer because the kitchen is short staffed. V9 said the facility has been short staffed for at least 2 months, and she ends up having to [NAME] sometimes. V9 said they are currently short a morning part time Cook, a part time Dietary Aide in the afternoon, a full time Dietary Aide in the morning, and an afternoon part time [NAME] position will be opening up on 10/20, when a staff member has their last day. On 10/9/24 starting at 10:57 AM, lunch service was observed, and the residents were served chicken enchiladas, street corn, and cheesecake. The facility's Spring Summer Menus 2024, Week 3 shows on Wednesday for Lunch the residents should be served Hawaiian Pork Sliders, pasta salad, pea salad, and cheesecake for dessert. The facility's Spring Summer Menus 2024, Week 3 shows on Monday for Lunch the residents should be served Chicken Enchiladas, Mexican Street Corn, and Dulce De Leche Cupcakes. The Monday Dinner shows the residents are supposed to be served an English Muffin Tuna Melt as their entree. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/9/24 at 3:20 PM, V9 (Dietary Manager) said she did not know how often or when, but there had been other occasions besides Monday and Wednesday of this week that she had to switch meals around or substitute meals due to insufficient staff. V9 said she just wants the residents to get fed on time. V9 said she tries not to switch meals around because the residents don't like change, and the littlest change disrupts them. V9 said that V1 (Administrator) has had to help her in the kitchen before because of lack of staff. V9 said she was not present for dinner service on Monday, but she was not aware that residents were served regular bread instead of toasted bread for their English Muffin Tuna Melts on 10/7/24. V9 said there should be 4 staff in the kitchen at any given time, not including the Dietary Manager: 1 Cook, 3 Aides and herself. V9 said on the weekends they only have 2 Aides and a [NAME] for breakfast and then an Aide comes in at 11 before Lunch service. V9 then provided the staffing schedule from 7/8/24 through 10/27/24 and highlighted all of the days they had/will have insufficient staff. These days include: 7/8/24, 7/9/24, 7/10/24, 7/12/24, 7/13/24, 7/14/24, 7/18/24, 7/19/24, 7/28/24, 7/29/24, 7/30/24, 7/31/24, 8/1/24, 8/2/24, 8/8/24, 8/9/24, 8/19/24, 8/20/24, 9/2/24, 9/7/24, 9/8/24, 9/17/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24, 9/30/24, 10/1/24, 10/2/24, 10/5/24, 10/6/24, 10/7/24, and 10/15/24. Out of 111 days, they had insufficient staff on 33 days. The facility provided Facility Assessment Tool, dated 12/13/2022, states, Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies . Staffing Plan 3.2 Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time .Example 1. Evaluation of the overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs . Dietician or Dietary Manager: 1 Dietician and 1 Dietary Manager, Food and Nutrition Staff: 3-4/3-4 . Example 2. Describe your general staffing plan to ensure that you have sufficient staff to meet the needs of the residents at any given time .Dietary Staff: 4 AM and 4 PM .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45906 Based on observation, interview, and record review the facility failed to follow their menus. This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen. Findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671), dated 10/8/24, documents the total census was 90 residents. On 10/8/24 at 10:58 AM, V9 (Dietary Manager) said all residents eat from the facility kitchen; there are no NPO (Nothing by Mouth) residents. On Wednesday 10/8/24 at 11:45 AM, R205 said on the previous Monday they were supposed to have tuna salad on toast, but it was not served on toast, it was just white bread. On 10/10/24 at 11:27 AM, R205 said there had been multiple occasions when the meals served did not match the menu, and that made R205 feel like her ability to choose had been taken away from her. On 10/8/24 at 10:27 AM, V9 said the facility does not have sufficient dietary staff. On 10/8/24 at 10:58 AM, V9 (Dietary Manager) said she switched the meals this week on Monday and Wednesday because they were short staffed on Monday. V9 said the Monday lunch meal was supposed to be chicken enchiladas, but chicken enchiladas have a long preparation time, and she only had 2 staff in the kitchen, herself and the cook. V9 said she is supposed to have at least 4 staff in the kitchen not including herself, the Dietary Manager. V9 said they should always be staffed with 1 Cook, 3 Dietary Aides, and 1 Dietary Manager. V9 said because she did not have enough staff on Monday, she prepared Wednesday's lunch on Monday, which was pulled pork, pasta salad, and pea salad. V9 said she does not want the resident's to suffer because the kitchen is short staffed. On 10/9/24 starting at 10:57 AM, lunch service was observed, and the residents were served chicken enchiladas, street corn, and cheesecake. The facility's Spring Summer Menus 2024, Week 3 shows on Wednesday for Lunch the residents should be served Hawaiian Pork Sliders, pasta salad, pea salad, and cheesecake for dessert. The facility's Spring Summer Menus 2024, Week 3 shows on Monday for Lunch the residents should be served Chicken Enchiladas, Mexican Street Corn, and Dulce De Leche Cupcakes. The Monday Dinner shows the residents are supposed to be served an English Muffin Tuna Melt as their entree. On 10/9/24 at 3:20 PM, V9 (Dietary Manager) said she did not know how often or when, but there had been other occasions besides Monday and Wednesday of this week that she had to switch meals around or substitute meals due to insufficient staff. V9 said she just wants the residents to get fed on time. V9 said she tries not to switch meals around because the residents don't like change, and the littlest change disrupts them. V9 said that V1 (Administrator) has had to help her in the kitchen before because of lack of staff. V9 said she was not present for dinner service on Monday, but she was not aware that residents were served regular bread instead of toasted bread for their English Muffin Tuna Melts on 10/7/24. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated policy titled, Menu Substitution Policy states, . Procedure: 1. Menu substitutions are necessary when a product is unavailable, residents request a substitution such as for Meal of the Month; or to take advantage of special pricing . This policy does not mention menu substitutions or switches are appropriate due to lack of sufficient kitchen staff.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to properly label/date/store items, remove expired items, sanitize equipment, and wear hair restraints in the facility kitchen. This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen. Findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671), dated [DATE], documents the total census was 90 residents. On [DATE] at 10:58 AM, V9 (Dietary Manager) said all residents eat from the facility kitchen; there are no NPO (Nothing by Mouth) residents. On [DATE] at 10:59 AM, V10 (Cook) was observed during lunch service. V10 checked the temperature of a tray of enchiladas and the placed the thermometer on the serving table, with the probe of the thermometer touching the table. The table was noted to have visible food debris/crumbs and dried liquid smudges on it. V10 then picked up the thermometer off the table, and without sanitizing the probe, stuck the thermometer in another tray of enchiladas to test the temperature. On [DATE] at 11:15 AM, V10 dropped the lid of a tray of enchiladas on the floor of the kitchen. V10 then picked up the lid off the kitchen floor with her oven mitts on, and placed the lid on the counter in the serving area. V10 then continued to use the same oven mitts to handle multiple food trays throughout lunch preparation. On [DATE] at 11:17 AM, V10 dropped the thermometer on the floor of the kitchen. V10 then picked up the thermometer off the floor and cleaned the probe with an alcohol wipe, but she did not alcohol wipe the digital display part of the thermometer which was also touching the floor. V10 then put the thermometer inside a small bin of enchiladas to check the temperature. The digital display portion of the thermometer was noted to be leaning against/touching the inside/side of the bin. On [DATE] at 11:36 AM, V11 (CNA/Certified Nurse Assistant) walked into the kitchen during lunch service, and walked past the meal trays being prepared for residents, with no hair restraint on. V11 had long pony tail that was swinging side to side while she was walking. On [DATE] at 11:49 AM, another CNA, V12, walked into the kitchen during lunch service to request a spoon from the kitchen staff. V12 did not put on a hairnet before entering the kitchen food prep area and her hair was not restrained. On [DATE] starting at 10:27 AM, the facility kitchen was toured in the presence of V9 (Dietary Manager) and the following was found: In the walk-in refrigerator: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. A bag of diced chicken with no label or date. 2. 2 5 pound bags of frozen egg product with no date. V9 said she did not know when the egg product was moved from the freezer to the refrigerator to thaw. 3. A 5 pound tub of non fat vanilla yogurt not dated. 4. A large tray of facility prepared grape salad with no label or date In the walk-in freezer: 5. A large tray of facility prepared half eaten ice cream cake without a label or date. In the dry storage: 6. 2 chocolate ready pie crusts with expiration date of [DATE]. In the kitchen prep area: 7. A medium tray of facility prepared caramel apple oatmeal cookies without a label or date. 8. 4 quart bin of baking powder with date of [DATE]. 9. On [DATE] at 11:52 AM a large 22 quart bin of powdered sugar was seen in the food prep area without a date on it. On [DATE] at 3:20 PM, V9 (Dietary Manager) said all food items in the kitchen are supposed to be labeled and dated so the staff know they are safe to serve to the residents. V9 said all expired foods should be thrown away by their expiration date to prevent them from being served to residents and causing foodborne illness. V9 said food items that are moved from the freezer to the refrigerator should probably be dated with a defrost date, because after the food is thawed, the kitchen staff only have 7 days before it is dangerous to serve to the residents. V9 said all staff who enter the kitchen are supposed to wear a hairnet because hair can get into the resident food and lead to illness or a resident choking on the hair. V9 said the thermometer digital display touching the inside of the enchilada bin after falling on the floor is potential for cross contamination, and the entire thermometer should have been sanitized after touching the kitchen floor. V9 (Dietary Manager) said V10 (Cook) should have brought the enchilada lid that fell on the floor straight to the dish room and not placed the lid on the table in the serving area. V9 said that is cross contamination from the floor to the serving area table. V9 said V10 should have alcohol wiped the thermometer probe after it touched the serving area and put the cover back on the probe until she checked the temperature of the next food item to prevent cross contamination. The facility's policy titled Labeling and Dating Foods (Date Marking), dated 2020, states, Guideline: All foods stored will be properly labeled according to the following guidelines. Procedure: 1 . Expiration dates on commercially prepared, dry storage food items will be followed. 2. Date marking for refrigerated storage food items . Once a case is opened, the individual, refrigerated food items are dated with the date the item was received into the facility and placed in/on the proper storage location .5 . The freezing date and the thawing date must be clearly labeled on the container . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy titled, Food Storage (Dry, Refrigerated, and Frozen), dated 2020, states, Guideline: . Food shall be stored .using appropriate methods to ensure the highest level of food safety. Procedure: 1. General storage guidelines to be followed: a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded . c. Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration . f. Leftover contents of cans and prepared food will be stored in covered, labeled and dated containers in refrigerators and/freezers . 3. Frozen storage guidelines to be followed: . d. When freezing food that has been prepared on site, ensure clear labeling of the item. The facility provided untitled and undated policy regarding hair restraints states, Policy: In order to prevent physical contamination of food by hair, hair restraints will be worn by . staff in specific areas of the kitchen. Procedure: 1. Staff shall wear hair restraints in all food production . 2. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food .

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F 0867 Level of Harm - Potential for minimal harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46409 Based on interview and record review, the facility failed to produce documentation or evidence of the yearly Performance Improvement Projects (PIP) for falls, identified by the facility as a problem-prone area. This has the potential to affect all 90 residents residing in the facility. The findings include: On 10/10/24 at 11:50 AM, V1 (Administrator) and V3 (ADON/Assistant Director of Nursing) conducted the QAPI/QAA (Quarterly Assurance and Performance Improvement/Quality Assessment and Assurance) task with the surveyor. V1 said she was unable to locate any documentation of the QAPI/QAA meetings and any information regarding the facility's PIP. V1 said they were also unable to provide any tracking or trending data to show which interventions were added to address the fall PIP, and whether these were effective in reducing the number of falls in the facility. At 12:30 PM, V3 said she had interventions in her head, but no interventions written out, as she had taken over QAPI two weeks prior. The facility's undated QAPI Feedback policy showed, It is the policy of this facility to collect feedback from staff, residents, and family members as part of the QAPI program. This is done in an effort to conduct structured, systematic investigations and analysis of underlying causes or contributing factors of problems affecting facility-wide processes that impact quality of care, quality of life, and resident safety. All identified problems will be addressed and prioritized, whether by frequency of data collection/monitoring or by the establishment of sub-committees chartered to complete performance improvement projects. The QAA committee will provide feedback by communicating the progress and outcomes of data collection/monitoring, as well as individually performance improvement projects, to interested parties such as staff, residents, and family members. The facility's undated QAPI Data Collection System policy showed, It is the policy of this facility to systematically collect data as part of the QAPI program to ensure the care and services it delivers meet acceptable standards of quality in accordance with recognized standards of practice. Data collection methodology is to be consistent, reproducible and accurate to produce valid and reliable data, and support all departments and the facility assessment. Performance indicators will be established based on data, and will be monitored/evaluated in the QAA Committee meetings.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46409 Based on interview and record review, the facility failed to hold a QAA (Quality Assessment and Assurance) meetings on a quarterly basis, and failed to have the appropriate committee members at QAA meetings. This has the potential to affect all 90 residents residing in the facility. The findings include: On 10/10/24 at 11:50 AM, V1 (Administrator) and V3 (ADON/Assistant Director of Nursing) conducted the QAPI/QAA (Quarterly Assurance and Performance Improvement/Quality Assessment and Assurance) task with the surveyor. V1 said the Medical Director did not participate in the last QAPI meeting since V3 took over two weeks before. V1 provided the sign in sheets for the QAA meetings, and the last meeting held was June 2024. V3 provided two sign-in sheets, dated 9/26/24 and 10/3/24, and said these meetings were not QAA meetings, but an introduction to what QAPI was for the staff attending. The 9/26/24 and 10/3/24 sign in sheets did not have the Medical Director in attendance. The facility's Quality Assessment and Assurance Committee policy showed, The Committee will be composed of staff who understand the characteristics and complexities of the care and services delivered in each unit and/or department. The QAA committee will be composed of, at a minimum: a. The Director of Nursing. b. The Medical Director or his/her designee. The QAA committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program. The committee will: a. Meet at least quarterly and as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46409 Based on observation, interview, and record review, the facility failed to follow infection control practices for residents under TBP (Transmission Based Precautions) and during transportation of dirty linen. This applies to 4 of 4 residents (R357, R356, R156, and R158) reviewed for infection control in a sample of 28. The findings include: 1. R357 was admitted to the facility with diagnoses including enterocolitis due to clostridium difficile. R357's POS (Physician Order Sheet) showed an order for Contact Isolation for CDIFF starting October 7, 2024. On 10/9/24 at 11:45 AM, V18 (Family Member) was in R357's room without wearing any PPE. V18 said goodbye to R357 and walked out of the room without washing her hands with soap and water. At 11:48 AM, V18 said she was in the facility every other day, and she was aware she was on isolation for C. Diff. V18 said she was never instructed on what she needed to wear prior to going into the room. V18 also said she was not instructed she needed to wash her hands prior to leaving the room. On 10/10/24 at 1:53 PM, V19 (Occupational Therapist) was in R357's room without any PPE (Personal Protective Equipment) on. On R357's doorway, there was signage posted for contact precautions and there was an isolation bin in front of her room with gowns and gloves in it. When V19 exited R357's room, she used Alcohol Based Hand Sanitizer. At 1:57 PM, V19 said she had gloves on in the room, and all she did was transfer the resident. V19 said R357 was under isolation for C. Diff. (Clostridium Difficile). V19 said she should have worn a gown, gloves, and mask, and wash hands with hand sanitizer prior to leaving the room. V19 said she was not aware she needed to wash her hands with soap and water. 2. R356's face sheet showed R356 was admitted to the facility with diagnoses including Parkinson's disease with dyskinesia, pressure ulcer of right buttock and left buttock, weakness, repeated falls, chronic fatigue, personal history of malignant neoplasm of prostate, and benign prostatic hyperplasia. R356's care plan dated 10/8/24 showed R356 was on Enhanced Barrier Precautions due to presence of foley catheter and wound with the goal being, Staff/Visitors will wear appropriate PPE when performing High-Contact Resident Care Activities. R356's POS showed an order dated 10/8/24 for Enhanced Barrier Precautions due to presence of foley catheter and wound. On October 8, 2024 at 12:23 PM, R356 was sitting in the wheelchair and his urinary catheter bag was on the ground. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/9/24 at 2:03 PM, R356 was sitting on the toilet and his wheelchair was next to him, which had the urinary catheter bag hanging underneath the wheelchair next to him. R356's call light was going off. R356 door had signage in place for EBP (Enhanced Barrier Precautions). At 2:05 PM, V13 (CNA/Certified Nurse Assistant) went to R356's room to answer his call light. V13 opened the isolation bin drawers and there were no gowns in the drawer. V13 put gloves on and went into the room and closed the door. V13 was assisting R356 in the bathroom, and the urinary catheter bag was on the ground, and V13 picked it off the ground and hung it underneath R356's wheelchair. On 10/9/24 at 2:08 PM, V13 said R356 was on isolation for MRSA (Methicillin Resistant Staphylococcus Aureus and she should have worn a gown, gloves and mask. V13 said she did not wear the gown because they were not provided in the isolation bin. V13 said she could contract MRSA by not wearing the appropriate PPE. On 10/10/24 at 1:59 PM, V20 (CNA) said for contact isolation, the staff should clean their hands, wear a gown and gloves, and wash hands with soap and water because C. Diff. is not killed using hand sanitizer. V20 said for EBP, staff should wear gowns and gloves when taking the residents to the bathroom or handling the urinary catheter. V20 also said the urinary catheter bag should not be placed on the ground. On 10/10/24 at 2:05 PM, V17 (CNA) said for contact isolation, staff need to clean hands, put on gowns and gloves, and wash hands with soap and water, as hand sanitizer is not appropriate to get C. Diff. infections off. V17 also said for EBP, she would wear a gown and gloves for high contact resident care. On 10/10/24 at 2:11 PM, V16 (CNA) said for contact isolation, the staff should wear a gown and gloves after cleaning hands, and then wash hands with soap and water before exiting the room. V16 said the urinary catheter bag should not go on the ground as the ground is dirty and could cause infections. On 10/10/24 at 2:40 PM, V2 (DON/Director of Nursing) said for contact isolation, the staff need to wear a gown and gloves only if they are getting within three feet of the resident. V2 said if the staff are dropping off a tray, they only need to wear gloves. V2 said for C. Diff., if the staff were to touch the resident, they would need to wear a gown and gloves, and can use 70% alcohol-based hand sanitizer. V2 reviewed the contact isolation signage, and said the sign showed to wash hands, put on gloves and gown before entering the room, and remove the gown and gloves before exiting the room. V2 said if their hands were visibly soiled, they should wash their hands. V2 said for EBP, the staff need to wear PPE when providing hygiene and assisting with toileting, and urinary catheter care. V2 said the staff should be notifying and educating resident families to wear the PPE for C. Diff., and to wash their hands with soap and water or alcohol-based hand sanitizer. V2 said if a family member is noncompliant, they should be care planned accordingly. V2 said the urinary catheter bag should not be placed on the ground as it could get contaminated and risk whatever was on the ground getting onto the tube and into the bladder. V2 said if it fell on the ground, he would expect the staff to clean the bag down. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Management of C. Difficile Infection policy, dated 10/1/24, showed Once confirmed, contact precautions shall be implemented in accordance with a physician order and facility policy for transmission-based precautions. General principles related to contact precautions for C. difficile: All staff are to wear gloves and a gown upon entry into the resident's room and while providing care for the resident with C. difficile infection. Hand hygiene shall be performed by handwashing with soap and water in accordance with facility policy for hand hygiene. The facility's undated Enhanced Barrier Precautions policy showed, Make gowns and gloves available immediately near or outside of the resident's room. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .High-contact resident care activities include: Providing hygiene . Changing briefs or assisting with toileting. Device care or use .urinary catheters. The facility's undated Catheter Care policy showed, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. 44387 3. On 10/8/24 at 10:52 AM, R158 called out for assistance. R158 was sitting up in bed watching TV. R158 said she needs some assistance. R158 pushed her call light at 10:53 AM. At 10:56 AM, V7 (Certified Nurse Aide/CNA) came in the room; R158 informed V7 her brief needed to be changed. V7 left to room to get supplies. V7 returned to the room, with gloves on, completed incontinent care on R158, removed soiled brief, and soiled draw sheet, took the soiled brief and draw sheet to the soiled utility room at the end of the hall. V7 did not change her gloves nor perform any hand hygiene after incontinent care. V7 also did not put the soiled brief and linen in a garbage bag prior to transporting it to the soiled utility room. 4. On 10/8/24 at 11:11 AM, R156 was sitting in her wheelchair in her room. R156 said she feels like her pants are wet and needs to get changed. R156's call light was pushed at 11:16 AM. V7 came in to R156's room and was informed R156 needed to be changed. V7 took R156 to the bathroom, put on gloves, did not use hand sanitizer; transfered R156 from the wheelchair to the toilet, removed wet brief and pants. V7 informed R156 not to get up from the toilet while she went to get clean pants for her in the room. V7 left the bathroom, did not take off her gloves or wash hands. V7 returned with clean pants, changed R156's brief, put on clean pants, transfered R156 back to her wheelchair, asked if R156 wanted to wash her hands. V7 washed R156's hands, took her back to her room. V7 put soiled brief in trash bag, took off her gloves, put on new gloves, then took soiled brief and wet pants to the soiled utility room. V7 did not put the wet pants in a garbage bag. On 10/9/24 at 11:09 AM, V15 (CNA) said they can wheel carts for soiled linen and trash outside the resident rooms to dispose of trash and soiled linen, or they can take the trash and soiled linen to the soiled utility room; they would have to put them in a garbage bag before leaving residents' room before taking it to the soiled utility room. On 10/10/24 at 9:21 AM, V3 (Assistant Director of Nursing/ADON) said soiled linen/laundry and soiled briefs should be placed in garbage bags before taking it to the soiled utility room. V3 said the CNA should have changed gloves and done hand hygiene during incontinent care and taken off her gloves before leaving bathroom to get clean pants for R156. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146077	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Estates at Morris	1223 Edgewater Morris, IL 60450

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Handling Soiled Linen policy (revised 10/1/24) states the facility will handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. Used or soiled linen shall be collected at the bedside (or point of use) and placed in a linen bag or designated lined receptacle; the bag shall be closed securely and placed in soiled utility room. The facility's Disposal of Garbage and Refuse policy (revised 10/1/24) states that the facility will properly dispose of garbage and refuse. The facility's Hand Hygiene Policy (no date) states that all staff will perform proper hand hygiene procedures to prevent the spread of infection other personnel, residents and visitors. The use of gloves does not replace hand hygiene, If tasks requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.