STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146096	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Health & Rehab Cntr	413 Ridge Lane Oblong, IL 62449

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to promote resident dignity by providing timely incontinence care for 3 (R1, R198, R21) of 6 residents reviewed for resident rights in the sample of 34. Findings include: 1. R1's Admission Record documented an admitted [DATE] and listed diagnoses including Congestive Heart Failure and Diabetes Type 2. R1's Minimum Data Set (MDS) dated [DATE] documented that R1 has no deficits in cognition and requires partial/moderate assistance for toileting and transfers. On 10/02/2024 at 11:11 a.m., R1, who was alert and oriented, stated the staff are slow to answer the call lights. R1 stated she will wait 30 minutes to an hour for staff to answer the call light. R1 stated that there are times she will be in the bathroom waiting for 30 minutes for the staff to answer her call light. 2. R198's Admission Record documented an admitted [DATE] and listed diagnoses including Chronic Obstructive Pulmonary Disease (COPD)and Anxiety Disorder. R198's Minimum Data Set, dated dated dated [DATE] documented that R198 has no deficit in cognition and is dependent on staff for toileting and transfers. On 10/02/2024 at 10:55 a.m., R198 was alert and oriented. R198 stated the wait for call lights to be answered is very long. R198 stated there are days she waits up to 1 hour for the staff to answer her call light. R198 stated she does not feel it is one shift or a particular day. R198 stated she experiences discomfort while holding urine/feces while waiting for staff. R198 said the facility is not fully staffed to take care of the residents. 3. R21's Admission Record documented an admitted [DATE] and documented diagnoses including COPD and Diabetes Type 2. R21's MDS dated [DATE] documented that R21 has no deficits in cognition, is totally dependent on staff for toileting and transfers, and has occasional urinary incontinence. On 10/03/2024 at 11:00 a.m., R21, who was alert and oriented, stated that she has to wait a long period of time for the staff to answer her call light. R21 will have incontinence episodes waiting on her call light to be answered. R21 stated she has had 4 episodes of incontinence today waiting on the call light to be answered. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 9:18am, V2, Director of Nurses, stated call lights should be answered as soon as possible, within 15 minutes at most. A Call Light Guidance Policy, dated 8/20/22, documents, Resident call light shall be responded to within a reasonable amount of time. It is the responsibility of all staff to respond to call lights. A Resident Rights Policy dated 7/11/22 stated, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: A. A dignified existence.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49714 Based on interview and record review, the facility failed to notify the resident or resident representative in writing of hospital transfers for 1 (R19) of 4 resident reviewed for hospitalization s in the sample of 34. Findings Include: R19's Admission Record documented an initial admitted to the facility of 01/12/2023. R19's Nursing Note documented on 08/02/2024 at 10:45 A.M., R19 was transported and admitted for observation for D-Dimer elevation, and redness to bilateral lower extremities. R19's Nursing Note dated 08/03/2024 at 1:20 P.M., documented R19 was transported to facility per daughter in a private vehicle. On 10/04/2024 at 10:30 A.M. V3 (Business Office Manager) stated she is the person responsible for sending out the notice of transfer to the resident and / or the resident representative. V3 initially stated that the resident was not out of the building for 24 hours. After reviewing the medical record, V3 stated she was not aware that the resident was out of the building for 24 hours. V3 stated that she missed sending out the notice of transfer on R19. V3 stated she thought the times that R19 went out were different. V3 stated she also does not keep a copy of the bed hold / transfer notification when she sends those to resident representative. Facility policy titled Discharge / Transfer Policy with a revision date of 08/15/2022 documented under section titled Procedure, 6. When the facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies bed to hold policy and the facilities policies regarding bed hold periods. The resident/resident responsible party will be given the Resident Rights Regarding Bed Holds and Bed Hold Form. Give a copy of the jointly signed and dated bed Hold form to the resident (or representative) and place a copy of it in the resident's medical record until the resident is readmitted .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 49714 Based on interview and record review, the facility failed to notify the resident or resident representative in writing of the bed hold policy during resident transfers for 1 (R19) of 4 residents reviewed for hospitalization in the sample of 34. Findings Include: R19's Admission Record documented an initial admitted to the facility of 01/12/2023. R19's Nursing Note documented on 08/02/2024 with a time of 10:45 A.M., R19 was transported and admitted for observation for D-Dimer elevation, and redness to bilateral lower extremities. R19's Nursing Note dated 08/03/2024 with a time od 1:20 P.M., documented R19 was transported to facility per daughter in a private vehicle. On 10/04/2024 at 10:30 A.M. V3 (Business Office Manager) stated she is the person responsible for sending out the bed hold and the notice of transfer to the resident and / or the resident representative. V3 initially stated that the resident was not out of the building for 24 hours. After reviewing the medical record, V3 stated she was not aware that the resident was out of the building for 24 hours. V3 stated that she missed sending out the notice of transfer and bed hold. V3 stated she thought the times the resident went out were different. V3 stated she also does not keep a copy of the bed hold / transfer notification when she sends those to resident representative. The facility policy titled Discharge / Transfer Policy with a revision date of 08/15/2022 documented under section titled Procedure, 6. When the facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies bed to hold policy and the facilities policies regarding bed hold periods. The resident/resident responsible party will be given the Resident Rights Regarding Bed Holds and Bed Hold Form. Give a copy of the jointly signed and dated bed Hold form to the resident (or representative) and place a copy of it in the resident's medical record until the resident is readmitted .

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36384 Based on observation, interview, and record review the facility failed to provide diets as ordered for residents with a nutritional risk for malnutrition for 4 of 4 (R13, R31, R33 and R38) residents reviewed for nutrition in a sample of 34. The Findings Include: 1. R13's Admission Record documents and admitted [DATE] and documents the following diagnoses: pressure ulcer of sacral region, Diabetes Mellitus Type 2, and Chronic Kidney Disease. R13's active Clinical Physician Orders with a print date of 10/9/24 documents a diet order of Consistent Carbohydrate Diet, Regular texture, thin liquids and double protein with all meals. On 10/3/24 at 12:30 PM, during lunch meal observation, R13 received one slice of meatloaf. On 10/4/24, at 12:35 PM, R13 received one slice of pizza. On 10/4/24 at 12:40 PM, V5 (Dietary Manager) confirmed that he only received one slice of pizza and would get him another slice as his diet order includes double protein at meals. 2. R31's Order Summary Report with a print date of 10/8/24 documents an admitted [DATE] and includes the following diagnoses: Type 2 Diabetes mellitus and Chronic Kidney Disease. The current diet order also listed on this sheet is Consistent Carbohydrate diet with regular thin liquids and double protein at meals. On 10/2/24 and 10/3/24 at 12:30 PM during lunch meal observation R9 was not observed to have double protein portions served to him. On 10/3/24 at 12:35 PM, V5 confirmed that R9 did not get the double protein at this meal, which should have been two portions of pizza. R31's Progress Notes written by V11 (Registered Dietitian) documented on 9/30/24 states that R31 is triggering for significant weight loss due to refusing meals due to not wanting the food. The Progress Note further states that he does not like the food at times and has a hard time eating it. V11 recommended to continue with current diet order and to liberalize the current diet to a regular diet with no carbohydrate restrictions. V11 also recommended an appetite stimulant if physician agrees. On 10/9/24 at 11:30 AM, V2 (Director of Nursing) stated that the diet had not been liberalized yet nor an appetite stimulant initiated due to the physician not addressing the recommendations. V2 cannot provide documentation to determine if the physician has seen the recommendation, nor if the staff has followed up with the physician since 9/30/24 to see if any new orders would result from V11's recommendations. V2 went on to state that she was had R31 re-weighed today due to the large decrease in one month that triggered him for a significant weight loss and he had not lost a significant amount of weight. V2 went on to state that she will review with the staff the need to re-weigh when a large weight change is noticed when entering the weights into the computer system. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R33's Order Summary Report with a print date of 10/8/24 documents an admitted [DATE] and includes the following diagnoses: dependent on renal dialysis, end stage renal disease, type 2 Diabetes Mellitus, and Anemia. The current diet order also listed on this sheet is Consistent Carbohydrate Diet, Mechanical Soft, Thin liquids and double protein. R33 also is to receive Med Pass 2.0 twice daily for malnutrition. On 10/2/24 at 12:45 PM, R33 had meatloaf for lunch and on 10/3/24 at 12:45 PM, R33 had pizza for lunch. V5 confirmed on 10/3/24 at 12:45 PM, that R33 should be receiving double meat portions at meals, but had only received one portion of the pizza and would go back to get him an additional serving to meet his current diet order. 4. R38's Order Summary Report documents an admitted [DATE]. This order sheet includes the following diagnoses: Chronic Kidney Disease and Hypertension. This same document lists the current diet order as: Pureed regular diet and Med Pass 30 milliliters three times a day. R38's Consultant Dietitian Recommendation to Physician authored by V11 documents a dietary recommendation on 9/9/24 of increasing the Med Pass to 50 milliliters three times a day. Under Reasoning it documents that R38 was admitted to the facility with diagnoses of dementia, chronic kidney disease, anemia, gastroesophageal reflux disease, hyperlipidemia, and hypertension. R38 is on a regular diet with mechanical soft texture and has fair intakes since admit. R38 is receiving MedPass 30 milliliters three times a day. Registered Dietitian recommending to increase to 60 milliliters three times a day. Under Physician/Prescriber Response the options of agree and disagree are left blank. On 10/8/24 at 2:30 PM, V2 stated that R38's Consultant Dietitian Recommendation to Physician was not previously sent to the physician and that she would ensure that it was communicated with her now to see if any new orders will be given. V2 confirmed this recommendation was not communicated to the physician to determine if new orders would be given.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to assess and manage pain for 1 (R198) of 2 residents reviewed for pain management in the sample of 34. This failure resulted in R198 experiencing severe pain and anxiety, resulting in a transfer to the ER (emergency room). Findings include: 1. R198's Admission Record documented an admitted [DATE] and listed diagnoses including Chronic Obstructive Pulmonary Disease and Anxiety Disorder. R198's Minimum Data Set, dated dated dated [DATE] documented that R198 has no deficit in cognition A Hospice Center Discharge Instructions Sheet dated 9/21/24 documented, Medications: Ativan 2mg. (milligrams) per ml. (milliliter), give 0.5ml by mouth every hour prn (as needed) for anxiety. Morphine Sulfate 20mg./ml. give 0.5ml by mouth every hour prn for pain/SOB (Shortness of Breath). R198's September 2024 Physician's Orders documented an order, Pain assessment every shift using 1-10 scale with a start date of 9/21/24. There were no medications documented to be started on 9/21/24. A September 2024 Medication Administration Record (MAR) contained no documentation that Ativan or Morphine were administered in that month. The same MAR documented that R198's pain was not assessed until 9/23/24 on the 6pm to 6am shift, at which time it was 2 on a scale of zero to ten. R198's Nursing Progress Notes documented the following: 9/21/24, 11:00am: Report received from hospice nurse. Nurse states that the resident is not eating any food but will occasionally sip on water or tea. She has a (name of indwelling urine catheter) in place. 2L NC (Oxygen at 2 liters, per nasal canula) for comfort. A&O x2 (Alert and oriented to person and place) intermittent confusion. Taking morphine for pain and ativan for agitation round the clock. Nurse states that the resident is being discharged from hospice and all orders will need to come from the admitting physician. 9/21/2024, 1:33pm: The resident arrived (to the facility) via EMS (Emergency Medical Services). 9/24/24, 5:30pm: Resident and family request to go to the ER for pain control. There was no documentation in the Progress Notes between 9/21/24 and 9/24/24 referencing R198's pain or anxiety. R198's Emergency Department (ED) Note dated 9/24/24 documented, (R198) presented to the Emergency Department for evaluation of lower abdominal pain that has been going on intermittently for the last few days. The pain is dull, 8 out of ten. Under Assessment/Plan it documents Abdominal pain, acute; acute cystitis; hypokalemia; Diagnosis: Cystitis (Urinary Tract Infection); abdominal pain; generalized weakness. Under Medication Reconciliation it documents Cephalexin 500mg.(miligram) oral every 12 hours for 10 days and Acetaminophen/Hydrocodone (Norco) 325mg-5mg, one tablet as needed every 6 hours for pain. Buspar 5mg. one tablet 3 times daily as needed for anxiety. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 10/08/24 at 12:01 PM, R198 was alert and oriented. R198 stated she was admitted on Saturday 9/21/24. R198 stated she was transferred from a hospice facility and was on round the clock medications for pain and anxiety. R198 stated she was told by facility staff that they would not be able to get these medications over the weekend. R198 stated shortly after her admission, she began to experience, Terrible pain in my abdomen, and anxiety, which exacerbated her breathing problems. R198 stated finally on 9/24/24 her family asked that she be sent to the ER to get the pain and anxiety under control. R198 stated the ER physician put her on new medications for pain and anxiety. On 10/09/24 at 9:18 AM, V2, Director of Nurses, stated when R198 was admitted on Saturday 9/21/24, she was transferred from a hospice program. V2 stated R198 had been on round the clock Ativan and Morphine, but came without medications. V2 stated normally when they get a new resident on the weekend they make sure they have the residents medication by Friday, but in this case, they were told R198 would be there on Friday, but she did not show up. V2 stated she was called the next day to say that R198 had arrived without medication. V2 stated she called the Medical Director on 9/21/24 to get medication orders for R198, but hard copy prescriptions were needed to get the medications and there was no way to obtain them. V2 further stated the pharmacy was closed, and even to take the medications out of the emergency kit, a written script was needed. V2 stated she is not sure why she did not document this call to the Medical Director. V2 stated on Monday 9/24/24, R198 was sent to the ED at the request of her family, where she was given orders for the Norco and Buspar. V2 stated every resident should have their pain assessed at least once every 12 hour shift. A Management of Pain Policy dated 5/16/22 documented, Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. A Medication Administration Policy dated 9/27/22 stated, Medications will be administered safely to residents within the facility by licensed nurses at the specified time/timeframe, following the recommended administration method and will be documented as required.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to provide sufficient direct care staff to meet resident's needs. This has the potential to effect all 49 residents living at the facility. Findings include: R1's Admission Record documented an admitted [DATE] and listed Diagnoses including Congestive Heart Failure and Diabetes Type 2. R1's Minimum Data Set (MDS) dated [DATE] documented that R1 has no deficits in cognition and requires partial/moderate assistance for toileting and transfers. On 10/02/2024 at 11:11 a.m., R1, who was alert and oriented, stated the staff are slow to answer the call lights. R1 stated she will wait 30 minutes to an hour for staff to answer the call light. R1 stated that there are times she will be in the bathroom waiting for 30 minutes for the staff to answer her call light. R198's Admission Record documented an admitted [DATE] and listed Diagnoses including Chronic Obstructive Pulmonary Disease (COPD)and Anxiety Disorder. R198's Minimum Data Set, dated dated dated [DATE] documented that R198 has no deficit in cognition and is dependent on staff for toileting and transfers. On 10/02/2024 at 10:55 a.m., R198 was alert and oriented. R198 stated the wait for call lights to be answered is very long. R198 stated there are days she waits up to 1 hour for the staff to answer her call light. R198 stated she does not feel it is one shift or a particular day. R198 stated she experiences discomfort while holding urine/feces while waiting for staff. R198 said the facility is not fully staffed to take care of the residents. R19's Admission Record documented an admitted [DATE] and listed Diagnoses including COPD and Glaucoma. R19's MDS dated [DATE] documented that R19 has moderate deficits in cognition and is independent for toileting and transfers. On 10/02/2024 at 11:08 am, R19, who was alert and oriented, stated the facility staff are slow to answer call lights. R19 stated it all depends on who is working how fast the staff answer the call lights. R19 stated there have been days she has waited over an hour for staff to answer the call light and take her to the bathroom. R3's Admission Record documented an admitted [DATE] and listed Diagnoses including Parkinson's Disease and Diabetes Type 2. R3's MDS dated [DATE] documented R3 has minimal deficits in cognition and requires partial/moderate assistance for toileting and transfers. On 10/02/2024 at 11:22 a.m., R3, who was alert and oriented, stated there have been 3-4 times recently that she has waited up to an hour for the staff to answer her call light. R3 stated the facility needs more help in order to be able to answer the call lights quickly. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R21's Admission Record documented an admitted [DATE] and documented Diagnoses including COPD and Diabetes Type 2. R21's MDS dated [DATE] documented that R21 has no deficits in cognition and is totally dependent on staff for toileting and transfers. On 10/03/2024 at 11:00 a.m., R21, who was alert and oriented, stated that she has to wait a long period of time for the staff to answer her call light. R21 will have incontinence episodes waiting on her call light to be answered. R21 stated she has had 4 episodes of incontinence today waiting on the call light to be answered. On 10/08/24 at 1:05pm, V2, Director of Nurses, stated she is the staff member responsible for scheduling the nurses and CNA's (Certified Nursing Assistants). V2 stated she schedules two nurses and 5 CNA's on the 6am to 6pm shift, and one nurse and 2 CNA's on the 6pm to 6am shift, with an additional CNA working 6pm to 10pm. V2 stated she has asked corporate for additional CNA's on the 6pm shift, and has been denied. On 10/9/24 at 9:18am, V2, Director of Nurses, stated call lights should be answered as soon as possible, within 15 minutes at most. An October 2024 Schedule documented that on 10/5/24 and 10/6/24, two CNA's and one nurse worked the 6pm to 6am shifts, including the period from 6pm to 10pm. A Staffing Policy dated 6/13/23 stated,3. Departmental work schedules may be revised by the Director of Nursing Services when deemed necessary and appropriate to ensure that each resident's needs are met. A Call Light Guidance Policy dated 8/20/22 documented, Resident call light shall be responded to within a reasonable amount of time. It is the responsibility of all staff to respond to call lights. The Long-Term Care Facility Application for Medicare and Medicaid form provided by the facility on 10/03/2024 documents the facility has 49 residents residing at the facility

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to acquire medications timely from the pharmacy for administration for 1 (R2) of 3 residents reviewed for pharmacy services in the sample of 34. Findings include: R2's Admission Record documented an admitted [DATE] and listed diagnoses including Hemiplegia and Hemiparesis affecting the right side, and Aphasia following a CVA (Cerebral Vascular Accident). R2's Minimum Data Set, dated dated dated [DATE] documented that R2's cognition is severely impaired. R2's 10/4/24 Emergency Department (ED) Notes under Discharge Orders documented,(Start) Ertanepem 1g (gram) in sodium chloride 0.9 percent (give) 1g every 24 hours start 10/5/24 for UTI (Urinary Tract Infection). R2's Progress Notes documented the following: 10/5/24, 2:33pm: Resident arrived back to facility via EMS (Emergency Medical Transport). Resident transferred into bed via 4 assist, resident received IV (Intravenous) ABT (Antibiotic) before leaving hospital. 10/06/24, 12:00pm: Notified MD (Medical Doctor) that ABT not in facility, stated to administer when ABT arrived to facility. 10/6/24, 1:37pm: Contacted (pharmacy) regarding residents ertapenem 1 GM (Gram) IV, they stated resident was not an active resident, and they did not service this area, also stated we would have to reactivate resident by sending facesheet and copy of order over to them, this was done yesterday as well, face sheet and order form resent over to (pharmacy), who was then called to verify that they received the order and facesheet, they stated that they did and ABT should be delivered tonight. On 10/09/24 at 9:18 AM, V2, Director of Nurses, stated R2 was not given the Ertapenem because the only pharmacy who is able to provide their IV medications was closed over the weekend. V2 stated R2's medication was obtained and administration started on 10/6/24 at 1:38pm. A Medication Administration Policy dated 9/27/22 stated, Medications will be administered safely to residents within the facility by licensed nurses at the specified time/timeframe, following the recommended administration method and will be documented as required.

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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** 49714 Based on observation, interview and record review the facility failed to ensure residents were free from unnecessary medications for 1 of 5 resident (R20) reviewed for unnecessary medications in the sample of 34. The Findings Include: R20's Admission Record documents an initial admission to the facility on [DATE]. The diagnoses listed on the Admission Record include the following: unspecified dementia as of 06/06/2023, anxiety disorder as of 09/20/2022, bipolar disorder as of 08/26/2022, major depressive disorder as of 10/17/2019, and insomnia as of 10/25/2023. R20's Order Summary Report with Active Orders As Of 10/09/2024 documented the following medications: Clonazepam 0.5 milligram (mg) give 0.5 tablet by mouth two times a day for anxiety, Doxepin 50 mg give 1 capsule by mouth at bedtime for depression, Olanzapine 2.5 mg tablet by mouth in the evening for Depression, and Venlafaxine 150 mg give 1 tablet by mouth one time a day for depression. R20's care plan has a focus area for (R20) is on anxiolytic therapy related to anxiety dated 02/15/2022. The goal for this focus area is (R20) will remain free from any adverse side effects from this medication through next review. The interventions for this focus area are administer medication as directed by physician; attempt GDR (Gradual Dose Reduction) when appropriate, ensuring lowest strength is utilized while continuing to adequately treat diagnosis; attempt to keep schedule of day-to-day activities the same, encourage verbalization of anxious thoughts / fears; ensure behavior tracking is in place; and limit environmental stimulation. R20's care plan has also has a focus area for (R20) is on antidepressant therapy related to major recurrent depression. The goal listed for this focus is (R20) will remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood by / through review date. The interventions listed for this focus area are: Administer medication as ordered; assist the resident in developing a program of activities that is meaningful, and of interest; observe for signs and symptoms of depression; and observe / document / report any signs and symptoms of depression including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health related complaints and tearfulness. On 10/02/2024 intermittent observations were made as follows: 12:20 P.M. R20 was in the dining room eating lunch, at 2:13 P.M. R20 was sleeping in her recliner in her room with the lights off. On 10/03/2024 intermittent observations were made as follows: 9:45 A.M. R20 was sleeping her in recliner in her room, at 1:45 P.M. R20 was observed sleeping in her recliner in her room. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document titled Consultant Pharmacist Recommendations to MD (Medical Director) dated 09/15/2023 documented Resident recently fell , and they have been on the following psychotropic therapy since 10-1-2022: Doxepin 50 mg by mouth every night. Note Doxepin is on the BEERS LIST - resident is [AGE] years old. Please review for a gradual dose reduction (GDR) as this may Reduce Fall Risk, such as Doxepin 25 mg po every night and document if any change in therapy is contraindicated. The Physician/Prescriber Response is left blank. According to the American Geriatric Society (https://agsjournals.onlinelibrary.[NAME].com/doi/epdf/10.1111/jgs.18372) the Beers Criteria is an explicit list of PIM's (Potentially Inappropriate Medication) that are typically avoided by older adults in most circumstances or under specific situations, such as in certain diseases or conditions. A document titled Consultant Pharmacist Recommendations to MD dated 04/22/2024 documented resident recently fell , and they have been on the following psychotropic since 04-17-2023: Clonazepan 0.25 mg po two times a day. Please review for a gradual dose reduction (GDR) as this may reduce fall risk, such as Clonazepam 0.25mg po daily and document if any change in therapy is contraindicated. The Physician/Prescriber Response is left blank. On 10/08/2024 at 2:30 PM, V2 (Director of Nursing) stated pharmacy consultant will review charts monthly and look at medications that need a gradual dose reduction attempted. V2 stated the consultant pharmacist will then email her the gradual dose reduction requests that need to be sent to the physician for approval or denial. V2 stated when she receives the gradual dose reductions from the pharmacist, V2 will then fax them over to the physicians. V2 stated that this is sometimes a problem as some of the physicians will not respond to the requests. V2 went on to say that she could not find anywhere on R20's chart where the physician had responded to either one of the gradual dose reduction requests. V2 stated she could not produce any documentation where the facility had sent the recommendation for R20 to the physician. August 2024 behavior tracking for R20, for the following behaviors: frequent crying, repeats movement, yelling / screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, rejection of care or none of the above observed. R20 had 7 shifts not documented/filled out for any of these behaviors. R20 had 55 shifts documented as none of these above listed behaviors were observed. September 2024 behavior tracking for R20, for the following behaviors: frequent crying, repeats movement, yelling / screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, rejection of care or none of the above observed. R20 had 9 shifts not documented/filled out for any of these behaviors. R20 had 51 shifts documented as none of these above listed behaviors were observed. The facility policy titled Unnecessary Medication Policy with a revision date of 11/03/2023 documented under Policy. It is the policy of the facility that all medications ordered by a physician shall have an appropriate indication for use, appropriate dosage/duration, and appropriate monitoring while in use. 4. Consulting pharmacist shall review resident's chart monthly for any abnormalities and notify Director of Nursing (DON) or designee of any abnormal findings and therapeutic recommendations. Director of Nursing shall notify ordering physician of recommendation promptly.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 49714 Based on observation, interview, and record review the facility failed to ensure medications were properly stored at appropriate temperatures. This failure has the potential to affect all 49 residents residing in the facility. Findings Include: On 10/04/24 01:23 P.M., the medication room was observed with V2 (Director of Nursing) present. V2 stated that the most recent temperature logs for the vaccine / medication fridge were in the binder on top of the fridge. V2 stated she is not sure why Septembers was not completed and had blanks where the temperature should have been recorded. V2 also stated she was unaware that there have not been any temperatures checked for the month of October 2024. V2 stated the facility has a medication storage policy but it is not specific to the checking of the refrigerator temperatures. On 10/09/2024 at 10:08 A.M. V2 stated that the midnight nurse is responsible for checking the temperature log and making sure it is documented on their shift. V2 stated that it had been completed since 10/04/2024. The Vaccine Fridge Temps log dated September 2024 had empty lines with no temperatures recorded on 09/05/2024, 09/18/2024, and 09/30/2024. The Vaccine Fridge Temps log dated October 2024 and reviewed on 10/04/2024, had no documentation on the form, indicating that facility staff had not checked the temperatures on the fridge in the month of October. On 10/04/2024 at 1:30 P.M., the medications stored in the medication refrigerator located in the medication room included: promethegan suppositories, 1 ozempic 8 mg pen, 1 liraglutide insulin pen, 1 novolg insulin vial, 2 insulin lispro vials, 1 humulin insulin vial, and 3 locked narcotic boxes. The facilities Medication Storage policy, with revision date of 08/23/2022, documents under Policy that the facility stores all drugs and biologicals in a safe, secure, and orderly manner and in accordance with state and federal regulations. Policy Interpretation and Implementation documents 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Per the US Food and Drug Administration (FDA) (www.fda.gov), it is recommended that insulin be stored in a refrigerator at approximately 36 F (Fahrenheit) to 46 F. Per the FDA Drug Database (www.accessdata.fda.gov) promethegan (promethazine) suppositories should be stored refrigerated between 36 F to 46 F and Ozempic injection should be refrigerated at 36 F to 46 F prior to the first use. The Long-Term Care Facility Application for Medicare and Medicaid form provided by the facility on 10/03/2024 documents the facility has 49 residents residing at the facility.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36384 Based on interview and record review, the facility failed to provide routine dental services for 1 of 1 (R31) residents reviewed for dental services in a sample of 34. The Findings Include: R31's Admission Record documents an admitted [DATE]. This same document includes the following diagnoses: Diabetes Mellitus, Hypertension, Polycystic Kidney Disease, and Gout. R31's July 29, 2024 quarterly Minimum Data Set (MDS) Section C, Cognitive Patterns, documents a BIMS Brief Interview of Mental Status (BIMS) score of 12, indicating R31 is cognitively intact. Section L, Oral/Dental Status, of this same MDS does not have an item checked for 1. Broken, loosely fitting full or partial dentures or 2. Mouth or facial pain, discomfort, or difficulty with chewing. R31's Care Plan does not include any dental concerns listed. On 10/2/24 at 10:00 AM, R31 stated that he has not had dentures since he came to this facility and has repeatedly wanted to get into a dentist to get them. R31 stated that it is hard for him to eat and feels like he is losing weight due to this concern. R31 stated that he has spoken to V1 (Administrator), V3 (Business Office Manager), and V8 (Previous Social Worker) about his request to see a dentist. On 10/2/24 at 12:45 PM, V1 stated that she did not know anything about R31 wanting a dentist appointment to get a set of upper dentures. V1 stated that she would speak with V3 tomorrow about it, as she is the one who makes these appointments so maybe she had some notes on it. V1 stated that they are currently working to get a dentist to come to the facility and see all the residents for dental needs if needed. On 10/3/24 at 1:30 PM, V3 stated that she does not have any information or notes on R31 needing a dentist appointment, but she is working to finalize a contract with a dentist to come to the facility monthly to see residents. V3 confirmed that no attempt to schedule an appointment for the dentist for R31 has been made. On 10/3/24 at 1:45PM, V1 stated that she cannot recall a time that he mentioned to her that he needs dentures replaced, but that he does not have upper teeth. V1 stated that V8 no longer works here, but R31 may have spoken to her about it and no follow up was done.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36384 Based on observation, interview, and record review the facility failed to ensure proper cooking time was reached when cooking meals for 4 of 4 (R18, R20, R23 and R27) residents reviewed for food preparation in a sample of 34. The Findings Include: R18's Order Summary Report for 10/2024 documents a diet order of: regular texture diet and thin/regular consistency. R20's Order Summary Report for 10/2024 documents a diet order of: No Added Salt diet, regular texture and thin liquid consistency. R23's Order Summary Report for 10/2024 documents a diet order of: No Added Salt, regular texture and thin liquid consistency. R27's Order Summary Report for 10/2024 documents a diet order of: Regular diet texture, thin liquid consistency. During the lunch meal observation on 10/2/24 at 11:45 AM, the meatloaf was being prepared to place on the serving table. V17 (Cook) was taking the temperature of the food items to be served to the residents. The meatloaf was showing a high temperature of 128 degrees Fahrenheit. V17 placed it back in the oven stating that she needs to achieve desired serving temperature of 160 degrees Fahrenheit. On 10/2/23 at 12:30 PM, during the lunch meal V17 was plating resident trays and staff were delivering them to the residents in the dining room. During this time R18, R20, R23 and R27 were observed to have meatloaf on their plate that was pink and cool in the center. R18 stated that she was trying to eat around the center to not eat the cool pink center of the patty. R20 stated that this has never happened, but she has a cool pink center of her meatloaf. R27 was eating the meatloaf, and when asked if she noticed the middle was pink she stated no but it was cool in temperature. At this time V5 (Dietary Supervisor) was told about the pink and cool center of the meatloaf and she removed the plates and provided new plates to these residents. V5 checked the temperature of the meatloaf and it was at 165 degrees Fahrenheit. On 10/3/23 at 12:00 PM, V17 stated that the meatloaf on 10/2/24 was made into single serving patties, rather than the loaf. V17 stated that several trays of meat loaf patties were prepared that day for the residents, and while each tray had a patty checked for internal cooking temperature, not every patty on the tray was checked. V17 stated that likely what happened was that some of the patties were not cooked thorough and were just not the patties that were checked on that tray. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The recipe for Meatloaf with Ketchup Glaze lists the following instructions: 1. In mixer bowl, combine ground beef, egg, onion, and bread crumbs; and tomato paste, Worcestershire sauce, garlic, Italian seasoning, salt, and pepper; mix on low speed 2-3 minutes just until blended. Do not over mix. 2. Spray steam table pans with non-stick cooking spray. Place meat mixture into steam table pan and shape into equal loaves. 3. Bake 30 minutes, remove pans from oven. 4. Spread ketchup evenly on top of each meatloaf. Return to oven and bake 30-35 minutes or until desired internal temperature is reached. Critical Control Point: Final internal cooking temperature 155 degrees Fahrenheit or above for 17 seconds. Critical Control Point: maintain hold 135 degrees Fahrenheit or above.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49714 Based on observation, interview, and record review the facility failed to clean the glucometer in between resident use for 3 (R7, R28, and R199) of 5 residents reviewed for glucose testing in the sample of 34. Findings Include: On 10/02/2024 at 11:26 A.M. V4 (Registered Nurse) obtained R7's blood glucose sample. V4 then placed the glucometer on the med cart on top of a towelette. V4 then draped the top part of the towelette over the glucometer. On 10/02/2024 at 11:34 A.M. V4 took the glucometer off the top of the med cart and obtained R28's blood glucose test. After getting the result and removing the test strip, V4 then placed the glucometer back on top of the med cart on the same towelette. V4 then draped part of the towelette over the glucometer. On 10/02/2024 at 11:39 A.M. V4 took the glucometer off the top of the med cart and obtained R199's blood glucose test. After getting the result and removing the test strip V4 then placed the glucometer on the med cart on top of the same towelette. V4 then draped part of the towelette over the glucometer. Medication pass continued until 12:07 P.M. At the time of the medication pass ending, the glucometer was still sitting on top of the medication cart on the same towelette. On 10/03/2024 at 1:57 P.M. V2 (Director of Nursing) stated it is her expectation that the nurses clean the glucometer after each use according to the policy. V2 stated that she would expect the nurses to use a new wipe to clean the glucometer after each resident use. On 10/08/2024 at 10:08 A.M. V4 stated that she is supposed to use a Sani - Wipe to clean the glucometer after each resident use. V4 stated the glucometer is supposed to stay wrapped up for 3 minutes after being cleaned. V4 then stated that when she did blood glucose checks on 10/02/2024 she did not clean the glucometer correctly. R7's Admission Record documented an initial admitted to the facility of 12/17/2020. Diagnoses listed on this document include: acute on chronic systolic heart failure, type 2 diabetes mellitus with diabetic neuropathy, unspecified atrial fibrillation, essential hypertension, and metabolic disorder. R7's Order Summary Report that documented Active Orders as of 10/08/2024 documents an order for Humalog to be given per sliding scale. On 10/09/2024 at 12:18 P.M. V15 (Regional Nurse) stated that the order for the Humalog was the order for glucometer. R28's Admission Record documented an initial admitted to the facility of 05/16/2024. Diagnoses listed on this document include: type 2 diabetes mellitus, unspecified diastolic congestive heart failure, obesity, anxiety, and essential hypertension. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's Order Summary Report that documented Active Orders As Of 10/08/2024 documents an order for blood glucose fingerstick monitoring TID before breakfast, lunch and dinner. R199's Admission Record documented an initial admitted to the facility of 12/30/2022. Diagnoses listed on this document include unspecified dementia, chronic obstructive pulmonary disease, type 2 diabetes mellitus, essential hypertension, and chronic kidney disease stage 3. R199's Order Summary Report that documented Active Orders As Of 10/08/2024 documents an order for Humalog to be given per sliding scale. On 10/09/2024 at 12:18 P.M. V15 (Regional Nurse) stated that the order for the Humalog was the order for blood glucose monitoring. On 10/08/2024 at 12:27 P.M. review of Sani-Cloth container under Cleaning procedure: All blood and other body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal cloth. Open, and unfold first germicidal cloth to remove visible disposal. Contact time: Use second germicidal cloth to thoroughly wet surface. Allow surface to remain wet for three minutes, let air dry. The facility policy titled Blood Sampling Capillary (Finger Stick) Procedure with no date, under the section titled Purpose documented The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent the transmission of bloodborne disease to residents and employees. Under the section titled Steps in Procedure 8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use.