STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146102	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Freeport	2170 West Navajo Drive Freeport, IL 61032

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39543 Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity for 3 of 3 residents (R57, R255, R51) reviewed for dignity in the sample of 24 and 3 residents (R101, R256, R105) outside of the sample. The findings include: 1. On 8/27/24 on 9:18 AM, R255 stated, I heard a commotion this morning. I am hard of hearing, and I could still hear it. It was a lot of 'You said this!' and 'No I didn't.' It was raised voices and way more than was necessary. It sounded like they were in their faces. I wanted to get up and say do you want me to come out there. It actually woke me up it was so loud. I wasn't mad but I was frustrated. They had no regard for us trying to sleep and it woke me up.So then I turn on my light and they (Certified Nursing Assistants/CNAs) say 'What do you want?' On 8/27/24 at 9:11 AM, R101 stated, There was staff feuding this morning at around 3:00 AM. It was loud. They were arguing about the working environment, and they didn't want to be here. It was very disturbing. By disturbing I mean just to here it and the arguing. It was very loud and not appropriate. It lasted about a half an hour. Half the time they (CNAs) come in the room and say 'What do you want?' They can be very rude. On 8/27/24 at 9:50 AM, R256 stated he heard the staff argument in the hallway outside his room. R256 said, I didn't have my hearing aide in this morning, and it (argument) woke me up, but I couldn't make out what they were saying. It was around 3:00 AM this morning. It made me feel like I shouldn't be here. It felt disrespectful. It was in our hallway. It was really loud.She (CNA) is very rude. She walks in, stops, and says 'What do you want?' She is very rude. On 8/27/24 at 2:18 PM, R105 said I did hear the staff yelling in the hallway this morning. It woke me up. The staff don't care about you here. Also, you put on the call light, and they say, 'What do you want?' and then you tell them (what you want) and you never see them again. It's not a dignified way to treat someone. (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: 146102	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at 2:46 PM, V2, Director of Nursing, stated, In regard to the incident the morning of 8/27/24, a CNA was arguing with the shift coordinator about her assignment. The CNA was told to go home. They should not have been arguing in the hallway. They should have taken the argument somewhere else. The CNA should have realized that this is the residents' home and not been yelling like that and woken them up. V2 also said, The CNA should not say 'What do you want?' They should say 'What can I help you with? or 'What do you need?' The residents would take it (the statement What do you want?) like they (CNAs) don't have time (to help the residents). The State of Illinois Residents' Rights for People in Long-term Care Facilities (Rev 11/2018) showed, Your facility must treat you with dignity and respect and must care for you in a manner the promotes your quality of life. 2. On 8/27/24 at 9:45 AM, V12, Certified Nursing Assistant (CNA), was looking at a personal cellphone when this surveyor entered the wing to do the medication storage task with V2, Director of Nursing (DON). Immediately upon seeing us, V12 put the phone in her pocket. On 8/27/24 during the Resident Council task, R51, R57, R101, and R255 said staff are on their cellphones all the time in resident care areas. R255 said, When they're on their phones, they're not caring for us. At 1:56 PM, V2, DON, said, Staff should not have their cell phones on them or be using them during resident care or when in resident care areas. It takes their focus away from the residents. The 6/3/24 resident council meeting minutes showed Certified Nursing Assistants (CNAs) are still on their cell phones. The 8/5/24 resident council meeting minutes showed CNAs are on their cell phones in the dining room while feeding residents on the day shift. Staff are talking on their ear buds while assisting residents. Staff eating their meals at mealtime while assisting residents on day shift. The facility's 4/2/19 Cell Phone and Electronic Handheld device Usage Policy showed a ban of cell phones in a facility is not only warranted but mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Employees may not use cell phones at work that can cause violations of privacy and breaches in confidentiality.

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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 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** 39543 Based on observation, interview, and record review, the facility failed to provide hand hygiene for 1 of 1 resident (R64) in the sample of 24. The findings include: On 8/27/24 at 1:18 PM, V18, R64's spouse, stated she wished the facility would clean R64's nails and hands. V18 said, He picks at his skin and I'm worried about him getting an infected wound from his dirty nails and all the picking he does. V18 then pointed out a scab on the middle of R64's forehead and stated he picks at the small wound often. On 8/27/24 at 1:18 PM, R64's nails and both hands had dirt and grime under all the nails. R64's hands were dirty with a dried red substance on his hands. R64 also had a small, pea sized, open, non-draining wound to the middle of his forehead. On 8/28/24 at 2:05 PM, R64's fingernails remained dirty; however, the red substance had been cleaned. On 8/28/24 at 2:42 PM, V20, Certified Nursing Assistant/CNA stated R64 does not refuse care and his is a good resident. V20 said, We wash hands anytime they are soiled and before meals. On 8/28/24 at 2:57 PM, V18 stated, I have told some of the nurses a few times to clean his nails. The surgeon said that he needed his nails trimmed and cleaned because of his picking, so I have told the nurses a few times, but it hasn't been done. On 8/28/24 at 2:46 PM, V2, Director of Nursing, stated, Staff should be washing resident hands before meals, when soiled, and after using the bathroom. V2 said staff should also be cleaning under the nails for cleanliness and infection control. On 8/28/24 at 2:56 PM, V2 observed R64's nails and stated his nails were dirty and they needed to be cleaned. R64's Quarterly Minimum Data Set (MDS), dated [DATE], showed he required substantial/maximal assistance for personal hygiene, which includes washing hands.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review, the facility failed to provide a dressing change in a manner to prevent cross contamination for 1 of 2 residents (R51) reviewed for quality of care in the sample of 24. The findings include: R51's face sheet showed he was admitted to the facility on [DATE], with diagnoses to include conversion disorder with seizures, gastrointestinal hemorrhage, bilateral inguinal hernia, severe morbid obesity, rash and other nonspecific skin eruption, and local infection of the skin and subcutaneous tissue. R51's physician order sheet showed, 8/26/24 Treatment for left side of scrotum: pack wound with iodoform and apply skin prep to surrounding skin and cover with band aid. change daily . On 8/27/24 at 2:08 PM, V5, LPN (Licensed Practical Nurse), and V29, CNA (Certified Nursing Assistant), were performing R51's dressing change to his scrotum. V29, CNA, was holding R51's scrotum for V5, LPN, to pack the wound. V5 was having a difficult time getting the packing into place. When V5 turned away to get some additional supplies, V29 using her same gloved hands which she was holding R51's scrotum with, reached to the buttons located on the footboard of the bed, and was attempting to adjust the height of the bed up. V29 touched all the buttons on the footboard of R51's bed as she was attempting to get the height of the bed adjusted. V29 then, using those same gloves, returned to R51 and started searching with her gloved hands to find the wound opening on R51's scrotum and touching the open area. When V5, LPN, turned back to continue attempting to pack the open wound she stated the bed was too high for her, and V29 then using those same gloved hands reached back down to the footboard and pushed the buttons to adjust the height, and again returned to R51 and began adjusting and readjusting his scrotum to find the open wound for V5 to continue the dressing change. On 8/29/24 at 12:03 PM, V2, DON (Director of Nursing), said if V29 was holding R51's scrotum, she should have taken the gloves off and washed her hands before touching the buttons on the bed. V2 said V29 should have then washed her hands and put on new gloves before touching him again. V2 said V29 would be contaminating both the resident and the buttons on the bed and potentially transmitting infection. The facility's policy and procedure with revision date of 03/04 showed, Wound Care . To protect the wound from contamination . Wounds are subject to infection . **Standard Precautions Must Be Followed During Care of Wounds. ** . All wound treatments should be done in an aseptic manner, employing standard precautions throughout .

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41639 Based on observation, interview, and record review, the facility failed to identify a pressure wound prior to becoming advanced stages, failed to identify deterioration of an existing pressure ulcer, failed to perform weekly wound assessments, failed to perform accurate wound assessments for 2 residents (R75, R63), failed to provide wound treatments, failed to maintain documentation of wound assessments for 1 resident (R16), and failed to ensure pressure ulcer prevention measures were in place for 1 resident (R63). These failures resulted in R75 experiencing sepsis requiring hospitalization , surgical debridement of his necrotic wound, and placement of a colostomy due to an infected wound. These failures also resulted in R63's bilateral heel wounds not being identified until they were unstageable wounds and becoming necrotic. These failures apply to 3 of 6 (R75, R63, R16) residents reviewed for pressure ulcers in the sample of 23. The findings include: 1. R75's electronic face sheet, printed on 8/29/24, showed R75 has diagnoses including but not limited to pressure ulcer stage 4, infection following sacral debridement, Parkinson's disease, Alzheimer's disease, dementia without behaviors, and colostomy. R75's care plan, dated 6/23/24, showed, Resident is at increased risk for pressure ulcers related to decreased mobility, generalized muscle weakness following recent illness and hospitalization . R75's admission nursing assessment, dated 7/17/24, showed R75 had no skin alterations upon admission. R75's care plan, dated 7/18/24, showed, (R75) has a colostomy related to sacral wound infection and need to keep the area clean. R75's facility assessment, dated 8/22/24, showed R75 has no cognitive impairment, has one stage 4 pressure ulcer, and utilizes and ostomy. R75's wound assessment report, dated 6/26/24, showed, dermatitis-7x6cm (centimeters). Red, open blisters to inner natal cleft. Scar tissue to coccyx and buttocks. Wound bed 50% slough and 50% granulated. Not recorded as pressure injury due to between skin folds. R75's wound assessment report, dated 7/3/24, showed, dermatitis-10x5cm-declining-macerated and excoriated scar tissue, grey in color. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R75's nursing progress notes showed, 7/4/24 Writer was taking resident to supper and noted his face appeared red and flushed. Writer took temperature and temperature was 101.2. Resident had some confusion to what time it was and seemed a bit slower than usual to respond. (Physician on call) notified gave order to restart cefdinir 300mg (milligrams) bid (twice per day) x 5 more days and if resident worsens tonight may send to emergency room . 7/5/24 Power of Attorney here and concerned that (R75) has confusion and was not acting like himself. Vitals taken temperature was 101.4. He is on antibiotic for UTI (urinary tract infection) .911 called and took resident to local emergency room . R75's local hospital records, dated 7/5/24, showed, .brought in for evaluation from nursing home after developing fever and altered mental status again yesterday. Daughter states he appeared to have some labored breathing from time to time as well .evidence of sepsis with urinary catheter has a large unstageable sacral decubitus foul-smelling necrotic wound that requires debridement sepsis criteria likely secondary to wound to coccyx. R75's operative note, dated 7/6/24, showed, Reason for operation: sepsis with necrotic decubitus ulcer . findings: necrotic decubitus involving skin and subcutaneous tissue with purulence (drainage) .scalpel was used to excise necrotic infected tissue . R75's surgery progress note, dated 7/8/24, showed, May need to consider diverting ostomy as patient seems to be intermittently incontinent of stool .wound is approximately 8-9cm in diameter and 5-6cm in depth . R75's surgery progress note, dated 7/9/24, showed, Discussed with patient and daughter that we suggest additional debridement of wound as well as construction of diverting ostomy for stool incontinence. They are in agreement .surgery within 24-48 hours. (R75's ostomy surgery was completed on 7/10/24) R75's hospital physician note, dated 7/10/24, showed, Sacral ulcer: wound cultures reporting prevotella and morgnella (bacteria). On 8/27/24 at 11:40AM, R75 stated, I have a horrible sore on my bottom. I got it while I was here and needed surgery on it, and then they gave me this (pointing to colostomy) because the sore was so bad. On 8/28/24 12:30PM, V17 (Wound Care Nurse) stated, (R75) had dermatitis, but I'm not exactly sure when it started. We were watching it and he had some areas that were red. I guess it broke open. I was doing the wound assessments for (R75) at the time. I don't really recall much about him, but looking at the physician communication notes, he must have had some chapped skin that we were trying to soften up or something. It's strange that there are no wound assessments other than the physician communication forms. I'm not sure where they would be or even how to find them. I would think if the nurse saw a change in the wound, she would notify the physician for new orders and document that. I'm only here one day a week, so if there is something new with the wound, then that is up to the floor staff to notify the physician. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 8/28/24 at 12:38PM, V2 (Director of Nursing) stated, There are nursing skin assessments in (R75's) chart, dated 6/18/24 and 6/26/24, but they do not show any open areas. I don't see any full wound assessments documented in (R75's) chart. It is the expectation that (V17) does a full wound assessment including measurements and characteristics of every resident with a wound when she is in the facility. If a new wound is identified when she is not here, then the floor staff do the assessment and initiate orders. It is also the expectation that if a change is seen with a wound, the staff notify the physician for new orders. We now have a Wound Physician that comes once a week, but he started after all of this with (R75), so he did not start seeing him until 7/22/24. On 8/29/24 at 11:07AM, V26 (Wound Care Physician) stated, It's not normal to change from dermatitis to an unstageable wound. It might have started as a stage one and then progressed to a higher stage, but this was never dermatitis. When you have granulation and slough, you don't have dermatitis. There is no broken skin with dermatitis. From the wound assessments that were performed initially, this wound should have been classified as a pressure ulcer and treated as such. It should have been reclassified as soon as his skin broke open. With the slough and granulation present, I would have probably classified this as a Stage 3 pressure ulcer initially. A wound can become necrotic within a few days if not receiving the proper wound care. The nurses should have noticed the wound was necrotic and odorous, and he should have been seen by a Wound Care Physician as soon as possible. When a wound becomes necrotic, it becomes very dark and liquified and very noticeable. He was not receiving the proper treatments for this wound, which led to the complications he had. The facility's policy titled, Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol, dated 10/24/22, showed, 6. When a resident is admitted to the facility or develops a pressure injury in the facility, the following will occur: A. Assess the pressure injury for location, size (measure length x width x depth), wound bed, drainage (amount, color, type), odor, tunneling, undermining or sinus tract, wound edges, surrounding tissue and pain at site. B. determine the injury's current stage of development: Stage 3 Pressure ulcer: full thickness skin loss: Full thickness loss of skin, in which subcutaneous fat is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slouch and/or eschar may be visible but does not obscure the depth of tissue loss .if slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/injury . 2. R63's face sheet, printed on 8/29/24, showed R63 has diagnoses including but not limited to peripheral vascular disease, pneumonia, pressure-induced deep tissue damage of left hip, atherosclerosis, and anxiety disorder. R63's facility assessment, dated 6/25/24, showed R63 has mild cognitive impairment and has 1 unstageable pressure ulcer. R63's care plan, dated 11/22/23, showed, (R63) is at increased risk for pressure ulcers related to decreased mobility, generalized muscle weakness following recent illness and hospitalization . Pressure areas present to heel, foot and hip. Apply pressure reducing waffle boots to lower extremities when at rest .pressure reducing device in wheelchair and bed. R63's wound management detail report, dated 12/13/23, showed, Right heel pressure ulcer-unstageable 2.5 x 5cm, 100% eschar, dark purple or rusty discoloration. R63 did not have a wound assessment performed 12/20/23 and 12/27/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R63's wound management detail report, dated 1/3/24, showed, Right heel pressure ulcer-unstageable deep tissue 2x5.8cm 100% necrotic eschar. On 8/27/24 at 11:02AM, R63 was laying in his bed with no heel protectors in place, and both of his heels were resting on the mattress. R63's heel protectors were observed on the spare bed in R63's room. On 8/27/24 at 11:26AM, V30 (hospice aide) provided incontinence care to R63, and stated R63 should always have his heel boots on because he has many wounds on his feet. V30 then transferred R63 to his wheelchair with no cushion in the chair. V30 stated R63 used to have a cushion, but she is unsure of where it is at. On 8/28/24 at 2:15PM, V2 (Director of Nursing) stated, All residents that are at risk for pressure ulcers and cannot reposition themselves should have heel protectors on at all times when they are in bed. If (R63) has that many wounds, then it is critical that all of the interventions are in place. I don't really know a lot about his wounds, but any wound should be identified as early as possible to allow for early intervention to try to heal the wounds. On 8/29/24 at 11:07AM, V26 (Wound Care Physician) stated, A deep tissue injury is intact skin with discoloration underneath. You cannot have a deep tissue injury with necrotic eschar. That is when the wound is open and becomes unstageable, so this assessment is incorrect. I wouldn't be surprised if that developed over a day or 2 without wearing heel protectors. If his skin was being assessed every day, this would have been caught when it was a red area; I would see a stage 1 red area. Wounds with eschar should be caught earlier and are signs that the wound is declining and is now open. 39543 3. R16's 8/27/24 Wound Clinic assessment showed she had a Stage 3 pressure injury to her left heel and two unstageable pressure wounds to her right foot. On 8/27/24 at 3:45 PM, R16 stated she has wounds on both of her feet. R16 stated her pressure wounds developed after she fell and sustained a fracture to her right ankle. R16 stated some of the pressure injuries developed while she had the cast on, and were not discovered until the cast was removed. R16 stated the pressure ulcer dressings were changed at the wound clinic on 8/27/24; however, prior to this, they had not been changed since Friday, 8/23/24. On 8/27/24 at 4:02 PM, V28, R16's daughter, stated she attended R16's wound clinic appointment that day. R16 stated the dressing was dated 8/23/24. On 8/28/24 at 12:19 PM, V16 (Wound Clinic Registered Nurse) stated she was the nurse who removed R16's dressing. V16 stated the dressings to both of R16's feet were dated 8/23/24. V16 stated the date on the dressing means the date that it was last changed. On 8/28/24 at 1:28 PM, V2 (Director of Nursing) stated the facility does not have the assessments for R16's wounds because the assessments are done at the wound clinic. V2 stated she did not believe the facility needed to keep records of R16's wounds if the weekly assessments were done outside the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R16's August 2024 Treatment Administration History (provided on 8/28/24, Commonly referred to as a TAR, Treatment Administration Record) showed an order to provide treatment and dressings to the left heel every 3 days. The TAR showed the treatment due on Monday 8/26/24 was left blank. R16's August 2024 TAR showed an order to treat and dress the wounds to the right foot every other day. The TAR showed the treatment due on Monday 8/26/24 was left blank. R16's Progress Notes from 8/26/24 (Monday, when the dressing changes were scheduled to be completed.) showed she left for an appointment at an unknown time; however, she returned at 4:30 PM. The progress notes do not show a refusal for dressing change. On 8/28/24 at 1:20 PM, V17 (Wound Nurse) (facility's wound nurse) stated, The date on the dressing is the date that it was changed. The purpose of the dressing is to removed exudate, promote healing and prevent infection. After a dressing change is done, they should document in the treatment list that the dressing change is done. The floor nurses do dressing changes when I am not here. I am here Wednesday. The dressings to both heels should have been changed Monday. If she (R16) refused, it should have been documented. I didn't assess them (foot wounds) she went to the wound clinic (the wound clinic assesses the wounds). One of them was pressure the other was due to a cast, I think. V17 stated she does not assess R16's wounds. The facility's Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol (revised 10/24/22) showed, . Weekly measurement will be conducted and entered in the chart under Wound Management .All treatments and charting of pressure ulcers/injuries will be done by licensed staff .

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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.

41639

Based on interview and record review, the facility failed to provide restorative exercises to 1 of 2 residents (R63) reviewed for range of motion in the sample of 23.

The findings include:

R63's electronic face sheet, printed on 8/29/24, showed R63 has diagnoses including but not limited to peripheral vascular disease, pneumonia, pressure-induced deep tissue damage of left hip, and anxiety disorder.

R63's facility assessment, dated 6/25/24, showed R63 has mild cognitive impairment and receives restorative nursing programs for active range of motion, bed mobility, and dressing and/or grooming.

R63's Therapy Recommendation/Communication), dated 1/1/24, showed, Suggested restorative programs: Transfers.

R63's Functional Abilities/Restorative Programs, dated 2/26/24, showed, Does the resident have a need for restorative programs-yes. Reason for restorative program-physical limitations. Describe resident's goals and summary of findings-restorative programs to be initiated.

R63's Functional Abilities/Restorative Programs, dated 6/24/24, showed, Reason for restorative assessments-physical limitations. Does the resident have a need for restorative programs-no. No restorative at this time. (R63) is enrolled in hospice. He is dependent for cares.

R63's electronic medical record showed no documentation of R63 receiving restorative services from 2/2024 thru 8/2024.

On 8/29/24 at 1:06PM, V22 (Minimum Data Set-MDS Coordinator) stated, I do all of the restorative assessments and set up the programming for all of the residents. Once the programming is entered into the resident's chart, then the aides perform the exercises. We don't have a Restorative Nurse or Restorative Aide; the floor staff perform all the programming. (R63) is not on a restorative program. I don't think he would really want to participate. He's hospice and does activity as he tolerates, he had no program prior to going hospice either. It's odd because I usually have them on everyone. I put a transfer restorative program and lower body exercises in on January I thought, but I don't see any documentation that it was ever completed by the staff. Of course, the one record you look at doesn't have any documentation. I must have missed this one.

On 8/29/24 at 1:13PM, R63 stated, They haven't offered to do any exercises with me, I feel bad asking them to do more than they already do because they are so busy. They only have so much time in the day. I would probably try to do a little something a now and again if they offered. I'm not sure how much it will help, but it couldn't hurt.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Nursing Rehab, dated 11/06, showed, It is the policy of the facility to provide a program to assist the resident to achieve and maintain the maximum level of function physically, mentally and socially .Restorative nursing care shall be a part of every resident's individual care plan

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review, the facility failed to implement interventions for residents with significant weight loss for 3 of 4 residents (R82, R70, R83) reviewed for weight loss in the sample of 24. These failures caused R82 to experience a 9.91% weight loss in 1 month, R70 to experience a 10.40% weight loss in 1 month, and R83 to experience a 12.18% weight loss in 1 month and a 18.55% weight loss in 3 months. The findings include: 1. R82's face sheet showed he was admitted to the facility on [DATE], with diagnoses to include chronic atrial fibrillation, congestive heart failure, pressure ulcer of sacral region, anxiety disorder, anemia in chronic kidney disease, and obstructive and reflux uropathy. On 8/28/24 at 9:12 AM, R82 said he has lost weight since he has been at the facility. R82 said he thinks maybe they may want him to lose weight. R82 said he is not on any nutritional supplements. R82's record showed on 7/11/2024, he weighed 212 lbs. (pounds) and on 8/08/2024, the resident weighed 191 pounds which is a 9.91 % weight loss in 30 days. R82's record showed the Nurse Practitioner was notified of the significant weight loss on 8/14/24 (6 days after the significant weight loss was identified). R82's Registered Dietitian Note dated 8/20/24 (12 days after the significant weight loss was identified) showed recommendations to complete weekly weights, nutritional shake twice daily, and continue to monitor intakes. R82's care plan for nutrition was started 8/28/24 (20 days after significant weight loss was identified). R82's care plan showed, Resident has experienced weight loss . Diet: Regular, high protein; encourage oral intake of food and fluids; monitor and record intake of food . There was not nutritional care plan in place prior to 8/28/24. On 8/28/24 at 3:46 PM, V3, ADON (Assistant Director of Nursing), said there are no meal intakes documented for R82. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 8/29/24 at 10:39 AM, V6 (Dietary Manager) said they have a few people who get fortified milk as a supplement, but they have no residents on fortified foods. V6 said if V27 (Registered Dietitian) recommends fortified foods, the resident would receive either mashed potatoes, soup, a cookie, or pudding. V6 said the CNAs get the weights and turn them in to him. He enters the weights and generates a report from the electronic health record which he gives to V2 (Director of Nursing), V3 (Assistant Director of Nursing), and V27 (Registered Dietitian, RD). V6 said the report is sent to V27 by email, since the facility does not have a permanent RD at this time. V6 said it has been about 4-6 months since they have had a permanent RD. V6 said the RD responds to let him know she received it and works on it at her convenience, whenever she has time. V6 said if V27 has recommendations, she emails them back to the DON to generate the changes. V6 said the nursing department puts the changes in to place and they change the diet card. V6 said R82 is on a high protein/high calorie diet and has no other nutritional supplements. V6 said the facility usually does an IDT (interdisciplinary team) meeting to discuss weights, but they have not had that meeting for the last few months since the kitchen has been short staffed. On 8/28/24 at 4:00 PM, V2, DON (Director of Nursing), said the facility does not start any nutritional supplements without a physician order. V2 said they notify the physician of weight changes, and they give the orders. The facility has no standing orders for nutritional supplements. On 8/29/24 at 12:09 PM, V2 said the RD does all her work remotely and does not come into the facility. V2 said she thinks the Registered Dietitian reviews residents with weight loss, new admissions, and those with their facility assessments coming up. V2 said she is not included in weight monitoring; all weights are given to V6, Dietary Manager. V2 said if the RD has recommendations, she writes it up and sends an email to her and to V6. V2 said recommendations are forwarded to the Nurse Practitioner, the resident's physician, or the Medical Director. V2 said those recommendations should be in place no later than 3 days after receiving them and they try and get them in place the same day or the next day. V2 said after the weight loss is identified, the RD should be reviewing as soon as possible. V2 said they don't monitor and document meal intakes on everyone, but they would do them for residents with weight loss. V2 said monitoring meal intakes would be put into place when the Dietary Manager enters the weight and identifies the weight loss. On 8/29/24 at 1:22 PM, V27 (Registered Dietitian) said she has been hired by the facility to cover until they find a permanent RD. V27 said she does all her work for the facility remotely, and was hired to work 8 hours per month. V27 said she lives out of state, and she goes in and enters notes on the residents she was referred to review every 2 weeks. V27 said V6 (Dietary Manager) sends her a list of residents to review, and she does a progress note for those. V27 said if she has recommendations, she writes those down and sends them to V6, Dietary Manger, and V2, DON. V27 said she would hope they would have those recommendations in place within the week of receiving them, but she would want interventions started right away. V27 said the gap between identifying the significant weight loss and starting interventions (18 days for R82) is too long because the residents could be losing more weight during that time. V27 said residents with a high protein/high calorie diet are supposed to receive fortified oatmeal at breakfast and fortified milk at all meals. 41639 2. R70's electronic face sheet, printed on 8/29/24, showed R70 has diagnosed including but not limited to dementia without behaviors, type 2 diabetes, peripheral vascular disease, and cognitive communication deficit. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R70's care plan, dated 8/28/24, showed, Resident has experienced weight loss. Monitor and record intake of food. On 7/11/24, R70 weighed 125 lbs. On 8/10/24, R70 weighed 112 pounds which is a 10.40 % weight loss within 1 month. R70's progress notes, dated 8/15/24, showed, (Nurse Practitioner) noted weight loss. No new orders. R70's Registered Dietician note, dated 8/20/24, showed, Per nursing note 8/15 (Nurse Practitioner) notified of weight loss with no new orders. Recommend Hi calorie diet. Will continue current nutrition interventions. Will continue to monitor intakes, weight, skin, and plan of care. R70's meal intake record for July and August 2024 had no documentation of meal intakes. R70's progress notes, dated 8/27/24, showed, (Nurse Practitioner) agreed with Dietician's request to change diet to Hi calorie diet due to recent weight loss. (17 days after weight loss identified). 3. R83's electronic face sheet, printed on 8/29/24, showed R83 has diagnoses including but not limited to dementia with behaviors, hypertension, and anxiety disorder. R83's facility assessment, dated 6/11/24, showed R83 has experienced a weight loss of 5% or more within 1 month or 10% or more within 6 months. R83's care plan, dated 8/28/24, showed, Resident has experienced weight loss. Monitor and record intake of food. On 5/8/24, R83 weighed 124lbs. On 8/8/24, R83 weighed 101lbs, which is a 18.55% loss in three months. On 7/11/24, R83 weighed 115 lbs. On 8/8/24, R83 weighed 101lbs, which is a 12.17% loss in one month. R83's progress notes, dated 8/15/24, showed, (Nurse Practitioner) noted weight loss no new orders. R83's Registered Dietician note, dated 8/20/24, showed, Resident continues to drop significant weight. Recommend increasing protein supplement to 8 oz three times a day and weekly weights. Will continue current nutrition interventions. Will continue to monitor intakes, weight, skin, and plan of care. R83's meal intake record for July and August 2024 had no documentation of meal intakes. R83's progress notes, dated 8/27/24, showed, (Nurse Practitioner) agreed with Dietician's request to increase residents' protein supplements and to add weekly weights due to recent weight loss. On 8/28/24 at 3:46PM, V23 (Assistant Director of Nursing) stated, We do not have meal intakes for these residents. We only chart by exception typically, so the only thing we have documented on them is whether they consume their supplements. I guess it would be helpful to know how much our residents are eating over time, but that's not our policy to document meal intakes on all residents. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility's policy titled, Weight Monitoring, dated 06/21, showed, Objective: To consistently assess residents for significant weight loss or gain .4. Licensed Staff will notify the physician of the following: A. 5% or more gain or loss in a 30-day period B. 7 1/2% or more gain or loss in a 90-day period C. 10% or more gain or loss in a 180-day period. 5. The weight committee will review all residents with significant weight gains or losses and other residents of concern and refer to the Registered Dietician as needed. 6. The Registered Dietician will review significant weight losses and any other residents referred by the weight committee on a monthly basis, and make recommendations to physicians as necessary.

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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.

35175

Based on observation, interview, and record review, the facility failed to ensure resident medications were clearly labeled and stored in a manner to prevent impairment of the integrity of the medicines for two of three medication carts reviewed for medication storage. This has a potential to affect all of the residents with medication stored in the two medication carts.

The findings include:

On 8/27/24, an open insulin flex pen was in the medication cart drawer in the dementia unit. It could not be determined by V2, Director of Nursing (DON), or V4, Licensed Practical Nurse (LPN), when the pen was opened or who it belonged to. A second medication cart as observed by V2 and V5, LPN, had an open insulin flex pen in the drawer. There was no date to determine when the medication was opened and no resident identifiers. A 500 milliliter (ml) bottle labeled valproic acid 250 milligrams (mg) had a little over 300 ml of liquid in the bottle. The label did not show the full concentration of the medication, had no legible resident information on it, and no open date. Another drawer had a second 500 ml bottle of valproic acid liquid. This bottle was wet and stuck to the bottom of the cart drawer when pulled out. There was no open date or clear resident identifiers on the label. There were also four unidentified white medication tablets on the drawer bottom.

08/28/24 at 10:56 AM, V2, DON, stated, Staff have been in serviced. We are to replace medications or have a new label issued if the label becomes illegible. Insulin pens should be dated when opened and labels on all medications should be legible. If a label is disintegrated, we should send the medication back to pharmacy. It's important to be able to read a label to ensure medicine is given to the right resident, the right amount, and so it's charged to the right resident. If pills are dropped, they should be discarded. If something is spilled it should be cleaned up.

The facility's 1/5/23 Pharmaceutical Procedures Policy showed, the label of each individual container filled by the pharmacist shall clearly indicate the resident's full name, physician's name, prescription number, name and strength of drug, directions for administration, date of issue, date of expiration of all time-dated drugs, the initials of the pharmacist filling the prescription, and amounts of medication contained in each prescription. In addition, the pharmacy's name, address, and phone number shall be on all prescriptions. Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels shall be returned to the issuing pharmacist for relabeling or disposal. Medications in containers having no labels should be destroyed in accordance with state and federal regulations. Drug supplies for the facility shall be stored under proper conditions of sanitation, temperature, light, refrigeration, and moisture. Resident's medications shall be properly labeled. The medications of each resident shall be kept and stored in their originally received container. All discontinues, unlabeled, and expired medications shall be returned to the pharmacy for proper disposition, and crediting considerations.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review, the facility failed to ensure resident preferences were considered for 1 of 1 resident (R9) reviewed for food preferences. The findings include: R9's face sheet showed she was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease, chronic atrial fibrillation, major depressive disorder, history of benign neoplasm of the brain, diarrhea, and unspecified nausea and vomiting. R9's facility assessment showed she is cognitively intact. On 8/28/24 at 10:39 AM, R9 said she has concerns regarding food at the facility. R9 had a log of the food concerns she had kept in a notebook. R9 expressed some of her food concerns, such as not receiving lemon with their iced tea, some specific food items that were overcooked and undercooked, food items not received, seasoning of food, temperature of food, and concerns regarding kitchen staff leaving immediately after they deliver the meals to the unit and residents being unable to ask for additional items from the kitchen. R9 said, These are all questions we want to ask the kitchen person, but they say they can't come to our food committee meetings because they are too busy. We hold the meeting monthly between 10:30 AM and 11:00 AM. The kitchen person has not been to our meeting for the last 3 months. The June, July, and August Food Committee meeting minutes were requested, but there were none available. The facility's March 2024 Food Committee Meeting Minutes showed the residents were requesting more fresh fruit, had concerns regarding the consistency of soups, receiving cold food, vegetables overcooked, and dry cake. The facility's April 2024 Food Committee Meeting Minutes showed the residents had concerns with the flavor of a soup and the seasoning of tomatoes. The facility's May 2024 Food Committee Meeting Minutes showed the residents had concerns with noodles being cold and undercooked, food being too cold, vegetables being over cooked, macaroni and cheese being overcooked, dry cakes, and staff leaving before finding out if the residents needed anything else. On 8/29/24 at 10:39 AM, V6 (Dietary Manager) said the facility has a specific Food Committee Meeting each month. V6 said he has not attended the meeting for the last three months because he hasn't had time since he has been cooking, due to being short staffed. V6 said the food committee meeting is a 30-minute meeting held right after the Resident Council meeting. V6 said someone should be in the meeting and bringing the residents' concerns to him verbally. The facility denied having a policy and procedure relating to their Food Committee Meeting. The facility's policy and procedure titled Menu Preference sheets was received but did not include anything regarding ensuring resident preferences are considered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35175 Based on observation, interview, and record review, the facility failed to implement COVID-19 outbreak interventions, failed to implement contact isolation precautions, and failed to implement enhanced barrier precaution interventions. This failure has the potential to affect all residents residing in the facility. The findings include: 1. The CMS 671, dated 8/27/24, showed 111 residents reside in the facility. On 8/28/24 at 8:25 AM, V13, R43's spouse, walked down R43's hall to the dining room at the end of the hall with no mask on. V13 had a loose, non-productive cough. V13 pushed R43 in her wheelchair from the dining room table and down the hall. Neither V13 nor R43 wore source control. None of the residents on the wing wore source control. Residents were leaving the dining room on their own and were seated less than four feet from each other at the dining tables. Staff assisted resident out of the dining room and down the hall with residents not using source control. Staff did not ask residents to wear masks. On 08/28/24 at 08:57 AM, V13 said nobody asked him to wear a mask today until he left the dining room with his wife. The girl at the front desk was busy when I came in. V13 said he has visited his wife daily for five years. On 08/28/24 at 09:02 AM, R99 was in a wheelchair without a mask on and in front of the dementia unit door. R99 was having difficulty opening the door. This surveyor got the attention of V21, Certified Nursing Assistnat/CNA. V21 said R99 was fine to go through the door as her spouse lived there. R99 entered the dementia unit and self-propelled halfway to the end. R99 said, Why would I wear a mask? Nobody asked me to put one on. At 09:48 AM, V3, Infection Preventionist (IP)/Registered Nurse (RN), said, (V8, Certified Nursing Assistant /CNA), tested positive for COVID last night while on duty. (V8) worked 8/25, 8/26, and 8/27/24 until 10:00 PM. (V8) worked two different wings and we have staff, residents, and visitors wearing masks on those units. Visitors are stopped at front door; we find out where they are going and ask them to wear a mask if it's one of the two affected wings. (V13) should have been asked to put a mask on when he entered the building to protect himself and others. If the CNAs knew (R99) was going down that wing, they should have asked her to put a mask on. At 11:18 AM, V9 said, Right before breakfast, (V2, Director of Nursing/DON), told (V10, CNA), the residents only needed to wear a mask if they left the wing or attended activities. About 8:25 AM this morning, (V11, CNA) shift supervisor called the phone in the dining room and told me she had a box of masks as the residents needed to wear a mask when they were out of their rooms. I asked for clarification as that's not what (V2) instructed us to do, and I never received a call back. What good will it do anyway? The residents are sitting two feet apart. At 11:20 AM, V10 said, (V2) told me at 6AM today that someone tested positive for COVID, and staff needed to wear masks on this hall. Nothing was said about the residents at that time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 10:56 PM, V2, DON, said, We are considered in outbreak status since the CNA tested positive for COVID (last night). Staff and residents should be wearing source control on the two units the CNA worked. The facility's 8/28/23 COVID-19 Policy showed the infection control program at this facility recognizes COVID-19 as a highly contagious virus and has a focus to reduce the risk of unnecessary exposures among residents, staff, and visitors. The facility will follow Centers for Disease Control and Prevention (CDC)/Centers for Medicare and Medicaid Services (CMS) recommendations regarding masking while in an outbreak. The CDC's 6/24/24 guidance showed source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances: By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days). 39543 2. R44's 8/26/24 Nurse's Note from 3:07 AM showed [R44's Physician] saw resident on 8/25/24, ordered stool for stool [sample] for GI Pathogen Panel, stool for C-Diff (Clostridioides difficile). On 8/27/24 at 11:22 AM, R44 stated she had been having diarrhea for several days. R44 stated, I can't leave my room because my diarrhea is so bad. I'm afraid I will have an accident in the dining room. On 8/27/24 at 11:22 AM, R44's room showed no signage indicating she was in isolation. On 8/28/24 at 2:36 PM, R44's room showed no signage indicating she was in isolation. On 8/28/24 at 10:30 AM, V19, Certified Nursing Assistant (CNA), stated R44 was not in isolation. V19 said, If there is no sign on the door for PPE (personal protective equipment), then we don't have to wear any special PPE. [R44], she doesn't have a [PPE] bin or sign on her door, but I would wear gloves when I would clean her up, but not a gown. She has been having diarrhea, but she doesn't have C-diff, otherwise we would know, and we would wear a gown. On 8/28/24 at 10:22 AM, V2, Director of Nursing, stated she was not able to find any evidence R44's stool sample had been sent to the laboratory. V2 stated if the sample had been sent, the results were not available. V2 stated, (R44) should be in contact isolation pending the results of the test and only removed from isolation if the results are negative. The purpose of the preemptive isolation is due to (R44) exhibiting the signs and symptoms of C-diff and to prevent the spread of C-Diff to staff and residents if she should be positive. The facility's Infection Control policy (Revised 12/17/19) showed, The purpose of isolation techniques is to protect the resident and personnel from infection and to halt the spread of the infectious agent .Gowns are worn by all personnel when they enter a strict isolation room and by those coming in direct contact with residents who require airborne, droplet and contact precautions . 41639 (continued on next page)

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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 - Many	3. R63's electronic face sheet, printed on 8/29/24, showed R63 has diagnoses including but not limited to peripheral vascular disease, pneumonia, pressure-induced deep tissue damage of left hip, and anxiety disorder. R63's facility assessment, dated 8/22/24, showed R63 has 1 unstageable wound and 5 venous ulcers. R63's care plan, dated 11/22/23, showed, (R63) is at increased risk for pressure ulcers .pressure areas present to heels, foot, and hip. Enhanced barrier precautions are in place . On 8/27/24 at 11:26AM, R63's door had a sign posted showing, Enhanced Barrier Precautions. Staff to wear gown, gloves, and eye protection (if necessary) during high contact resident care activities including transfers, personal hygiene . Outside R63's door was a cart with surgical masks, gowns, and gloves. V30 was in R63's room providing incontinence care, bathing assistance, and transfer assistance, with only a gown and gloves on. V30 stated R63 is not on any type of precautions that she is aware of. On 8/28/24 at 2:02PM, V2 (Director of Nursing) stated, All residents on Enhanced Barrier Precautions have a sign on their door instructing staff to wear gowns and gloves with high touch resident care activities, which does include transfers, toileting, and personal hygiene. This is not new information, and our staff know that. Even our contracted staff are in here all the time, so they know what our policy is. 4. R75's electronic face sheet, printed on 8/29/24, showed R75 has diagnoses including but not limited to pressure ulcer stage 4, infection following surgical debridement, and colostomy. R75's facility assessment, dated 8/22/24, showed R75 has 1 stage 4 pressure ulcer, utilizes a urinary catheter, and has a colostomy. On 8/27/24 at 7:58AM, R75's door had a sign posted showing, Enhanced Barrier Precautions. Staff to wear gown, gloves, and eye protection (if necessary) during high contact resident care activities including transfers, personal hygiene . Outside R75's door was a cart with surgical masks, gowns, and gloves. V24 and V25 (Certified Nursing Assistants) were providing personal cares and bathing assistance for R75, and only had gloves applied. V24 and V25 did not have a gown on. V25 stated, I didn't see any type of isolation sign out there before I came in. V24 stated, I don't think he's on any type of isolation. The facility's policy titled, Enhanced Barrier Precautions, dated 8/8/22, showed, It is the policy of the facility to use proper personal protective equipment (PPE) during high-contact resident care activities that provide opportunities for transfer of multi-drug resistant organisms (MDROs) to staff hands and clothing .1. EBP (Enhanced Barrier Precautions) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities . Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care, wound care .