STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146112	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Bradley	650 North Kinzie Ave Bradley, IL 60915

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on observation, interview, and record review, the facility failed to provide a dignified dining experience to residents who require feeding assistance. The facility also failed to provide dignity in wound care by not closing windows during wound care. This applies to 5 of 8 residents (R5, R17, R18, R22, and R24) reviewed for dignified resident care in a sample of 25. The Findings include: 1. R299 is a [AGE] year-old female with severe cognitive impairment as per the Minimum Data Set (MDS) dated [DATE]. The MDS also documents that R299 requires partial/moderate assistance with eating. 2. R18 is a [AGE] year-old male with cognition intact as per the MDS dated [DATE] and requiring substantial/maximal assistance for eating. 3. R22 is a [AGE] year-old male with severely impaired cognition as per the MDS dated [DATE] and with an admitting diagnosis, including hemiplegia affecting the right dominant side secondary to cerebral infarction. 4. R24 is a [AGE] year-old female with severely impaired cognition as per the MDS dated [DATE] and requiring partial/moderate assistance for eating. On 5/15/24 at 12:25 PM, observed seven residents (R299, R18, R22, R24, R48, R27, and R62) around a dining table during lunch. Observed R299, R18, R22, and R48 were not fed while V11 (MDS coordinator) was feeding R48, V12 (Certified Nursing Assistant/CNA) was feeding R27, and V13 (CNA) was feeding R62. On 5/15/24 at 12:30 PM, R18 stated, - I want to eat. I am hungry. On 5/15/24 at 12:30 PM, V11 stated, We are on the way to feed remaining residents. On 5/16/24 at 10:05 AM, V5 (Assistant Director of Nursing/ADON) stated, The residents should have a dignified feeding experience. They should have called for more staff to feed those not fed and watch feeding other residents. 41384 (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 05/14/24 at 11:26 AM, R17 was being provided wound care to her lower abdominal area. V5 Assistant Director of Nursing (ADON/Wound Nurse) attempted to close the blinds but there were several missing panels, therefore leaving the blinds open. V5 then provided wound care to R17, leaving R17 exposed from her abdomen to her upper thighs. R17's room was right next to the sidewalk that leads to the patio and gazebo, all viewable from the window. On 05/16/24 at 10:29 AM V1 (Administrator) said that the nurse should have put something up on the window to prevent people from seeing in for privacy purposes. The facility's Dignity policy dated 2/2018 showed, the facility shall promote care for resident in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and Record review the facility failed to provide a comfortable wheelchair for one (R65) resident reviewed for mobility in a sample of 25 residents. Findings include: R65 was admitted to the facility on [DATE]. R65's MDS (Minimum Data Set) dated 3/11/24 shows he is cognitively intact with a BIMS ((Brief Interview for Mental Status) score of 15. R65's MDS shows the use of a wheelchair for mobility. R65's diagnoses include morbid obesity, abnormal posture, lack of coordination, reduced mobility, osteoarthritis, and chronic gout. R65's physician orders include may participate in outings. R65's current care plan includes ADL (Activities of Daily Living) / mobility performance deficit that may fluctuate with activity throughout the day related to limited mobility, musculoskeletal impairment, abnormal posture and lack of coordination. No documentation found in R65's EMR (Electronic Medical Record) the reason for his refusal to use the facility provided wheelchair. Review of R65's EMR show he was discharged from physical therapy on 1/15/2024. The facility did not provide a policy on resident required equipment. On 5/14/24 at 11:55 AM, R65 was observed gowned and lying in bed. R65 stated he did not have a wheelchair to get out of bed. R65 stated the wheelchair the facility previously provided to him was too small and was too painful to use. R65 stated the facility does not have a wheelchair that is comfortable for his size and body type. On 5/16/24 at 10:46 AM, V17 Director of Rehab) stated R65 was offered a wheelchair and he refused it because it was too low for him. V17 stated there are wheelchairs that are a little higher. V17 stated if R65 required a higher sitting wheelchair it would have to be customed ordered. V17 stated therapy would need to coordinate with the Nurse Practitioner and the wheelchair company to be approved. V17 stated the process to obtain a custom wheelchair was never started. On 5/16/24 at 4:40PM, V16 Facility Consultant stated she did not have documentation as to why R65 refused to utilize the wheelchair previously provided.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 41384 Based on observation, interview, and record review the facility failed to ensure that 1 resident (R50) was free from physical restraints imposed for staff's convenience in a sample of 25. Findings include: On 05/15/24 at 9:13 AM, R50 was not in his room. V4 (nurse) said that R50 was not in his room because he tries to stand up all the time, so we bring him to the nurses' station. At 9:15 AM V50 was observed at the nurses' station and no staff were present at the time. R50 was observed sitting at a table and his chair was pushed up against the table with the wheels locked. R50 was observed rocking in his chair attempting to stand up. V4 said that the table is in front of R50 to keep him from standing up. V4 said that R50 always tries to get up and the table keeps him from getting up. V4 said R50 can actually walk but he will wonder in the hallway, and he is wobbly and unstable, and this is why we keep him at the table. V4 said they usually put R50 at the nurse's station to keep him from standing up and wandering. On 05/16/24 at 11:14 AM V1 (Administrator) said that the staff should not be restraining residents, there is a fall prevention care plan and we can't use restraints for fall precautions. V1 said R50 should not have been put behind a table to restrain his movement. A review of R50's electronic health record did not show an order to restrain R50's movement or mobility at any time, nor did R50's care plan show any fall preventions with interventions of restraining R50's mobility/movement. The facility's Restraints policy dated 5/2018 showed, physical restraints may include but are not limited to placing a resident in a chair that prevents him from rising. convenience is defined as any action taken by the facility to control a residents' behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest. Freedom of movement means any change in place or position for the body or any part of the body that the person is physically able to control.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observation, interview, and record review the facility failed to provide the necessary care and services to maintain their ability to carry out the activities of daily living with regards to communication for 2 Spanish speaking only residents (R45 & R77) in a sample of 25. Findings include: On 05/14/24 at 1:30 PM R45 and R77 were observed in their shared room. V14 (Certified Nurse's Assistant) said that R45 and R77 are Spanish speaking, and she can't communicate with them because she does not know Spanish. R45 was asked if she needed anything and R45 replied in Spanish. V14 said I can't communicate with her. Sometimes I don't know what she is saying. V14 then asked R77 if she needed anything and R77 replied in Spanish. V14 then said, I don't know what she says. I don't know if they need anything right now and I don't know what to do. R77 continued speaking and V14 just left the room without even acknowledging her. 1. R45 electronic health record review showed that R45 is a Spanish speaking only [AGE] year old female admitted to the facility on [DATE]. R45's 1/29/23 MDS (minimum data set) Sect b. showed - understands verbal content 2. Sometimes. R45's 3/7/24 care plan showed that R45 is not able to communicate needs due to poor cognition. Words are nonsensical and repetitive at times. Interventions included, staff may ask for a Spanish speaking employee or a family member or use a translation service when speaking to R45. R45 care plan showed under activities, I have had a decline in health resulting in a significant change. I have been diagnosed with a multiple list of conditions and diagnoses; my memory is poor. I rarely speak, my main language is Spanish. Interventions included offer communication board if she prefers to communicate with other non- speaking Spanish Staff. On 05/16/24 at 10:52 AM V1 (Administrator) said that R45 should have a communication board if it is in her care plan. V1 said that it could be difficult to meet her needs without a Spanish speaking person/interpreter or communication board for her 24 hour care needs. 2. R77 electronic health record showed that R77 is an [AGE] year old Spanish speaking female admitted to the facility on [DATE]. R77's 4/23/24 social service social history showed under #10 Preferred language - answer Spanish, #11. Do you need or want an interpreter to communicate with doctor or healthcare staff? - answer Yes. #12. How often do you need to have someone help you when you read instructions, pamphlets, other written material? - answer Always. R77's 4/23/24 MDS CAA (care area assessment) worksheet 4. communication showed speaks different language - do you need or want interpreter? - 1. Yes. Language.: Do you need or want an interpreter to communicate with a doctor or health care staff? -answer Yes. On 05/16/24 at 10:30 AM V1 (Administrator) said that R77 should have Spanish speaking staff and she should have an interpreter. The V16 (facility's consultant) reported that the facility does not have a communication policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observation, interview, and record review, the facility failed to provide timely ADL (Activities of Daily Living) to 3 dependent residents (R9, R29 & R32) in a sample of 25. 1. On 05/14/24 at 12:41 PM, R29 was observed with long jagged nails and facial hair on her chin, about 1/2 inch long. On 05/15/24 at 12:14 PM R29 was observed with long jagged nails and facial hairs on her chin. R29's 5/21/24 care plan showed R29 had an ADL self-care/mobility performance deficit that may fluctuate with activity throughout the day. R29's 3/20/24 MDS (minimum data set) section GG showed under personal hygiene that R29 was dependent for personal hygiene. On 05/16/24 at 10:44 AM V1 (Administrator) said that R29 should not have had facial hair and her nails should have been maintained for dignity, hygiene and self-feeling good and safety. V1 said R29's jagged nails could cause her to scratch herself or someone else. 2. On 05/14/24 01:45 PM R32 was observed with facial hair on both sides of her mouth up to 2 inches in length. R32 was asked how she felt about the facial hair and her reply was that she felt neglected. R32 said that staff does not want to help her shower when she requests it. R32 said that she smells, and that she doesn't get showers when she asks. R32's 2/13/24 MDS (minimum data set) section GG showed under personal hygiene, needs supervision or touching assistance and under Bathing needs partial moderate assistance. R32's 5/7/24 care plan showed R32 has and an ADL self-care/mobility performance deficit that may fluctuate with activity throughout the day. R32's electronic health records under Task showed for the last 30 days for Shower/Bathe - No documentation, and for the last 30 days of, Bathing Tuesday and Friday PM showed only 4 days of documentation (5/3/24, 5/7/24 & 5/10/24). On 05/16/24 at 11:02 AM, V1 (Administrator) said that R32 should receive a shower or bed bath as needed or according to her care plan. The facility's Morning Care policy dated 01/2018 showed that the purpose is to promote comfort, cleanliness and dignity. The facility's Nail Care policy dated 01/2018 showed observe condition of resident's nails during each time of bathing. Note cleanliness, length, uneven edges. 34410 3. R9 is a [AGE] year-old female admitted on [DATE] with moderately impaired cognition as per the minimum data set (MDS) dated [DATE]. MDS also indicates that R9 requires substantial/maximal assistance on toilet hygiene. On 5/14/24 at 11:30 AM, the writer observed R9's room with intense urine/feces smell. In response to this writer's request V8 (Certified Nursing Assistant/CNA) checked on R9 and found with thick watery bowel movement with stool smeared all around perinium up to below her abdominal fold. On 5/14/24 V8 stated that she checked R9 at 6:15 AM and they are supposed to check on residents for incontinent care every two hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 10:24 AM, V2 (Director of Nursing/ DON) stated that incontinent care should be provided every two hours and as needed. A review of R9's bowel and bladder incontinent care plan document: Check and change x 3 times every shift and as required. Wash, rinse, and dry perineum. The facility presented Incontinence Care policy with effective date 03/2024 document: Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observation, interview, and record review the facility failed to provide activities for 4 residents (R17, R29, R50 & R44) based on their care plans in a sample of 25. 1. on [DATE] at 11:44 AM, R17 was observed in her room. V15 (R17's son) was present at the time. V15 said that the facility does not provide activities for his mother. V15 said Someone used to come around and spend time with her, but she died . Now no one comes by. V15 said that he is at the facility everyday A review of R17's electronic health records showed no 1:1 activity for the last 30 days. R17's [DATE] care plan showed activities care need with interventions including, express satisfaction with level and type of involvement in leisure activities during one on one visits ,d+[DATE]xweekly. 2. During tours of the facility on [DATE], [DATE] & [DATE], R29 was never observed in any 1:1 activity. A review of R29's last 30 days of 1:1 activity program showed, No documentation. R29's [DATE] Care plan showed a care need for activities with interventions including, will accept/participate in 1:1 visits, 2 times per week, and the facility will provide 2 1:1 visits weekly. On [DATE] at 10:50 AM V1 (Administrator) said that R17 should have been receiving daily activities. 3. On [DATE] at 9:15 AM, R50 was observed sitting at a table next to the nurse's station with a word puzzle in front of him and no writing utensil present. R50 was observed with his eyes closed and rocking in his chair attempting to get up. V4 (Nurse) said that R50 could not do the puzzle and removed it. There were no stimuli like music or a TV on at the time of the observation. R50's electronic health record showed that R50 is a [AGE] year old male admitted to the facility on [DATE] with diagnoses including severe dementia and severly impaired cognition. On [DATE] a review of R50's last 30 days of 1:1 activity program showed, No Documentation. R50's [DATE] care plan showed a care need for activities with interventions including, listen to music, watch television, and keep up with the news. [DATE] 11:06 AM V1 (Administrator) said that R50 should be provided daily activities that he can do according to his abilities. V1 said that R50 should not have been given a word puzzle because it was not suitable for him. V1 said that R50 should be given things according to his care plan that he enjoys, like music. On [DATE] at 2:33 PM V3 (Activities Director) provided the facility's One on One List (no date), R17, R29, & R50) were on the list. V3 said that the list was for the bed bound residents and the facility only scheduled one on one activities once a week but has not been able to provide one on one services for the last 2 to 3 months. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Activities Program policy dated ,d+[DATE] showed, the purpose is to provide an ongoing program of activities designed to appeal to the residents' interest and to enhance his or her highest practical level of physical mental and psychosocial well-being. Guidelines show identify and involve each resident in an ongoing program of activities that is designed to appeal to his or her interest and needs. The staff shall record residents' activity attendance and participation on a daily basis. 46003 4. R44 has diagnoses that includes aphasia, type 2 diabetes, hemiplegia, depression, pseudobulbar affect and epilepsy, R44's current activities care plan focus states activities to visit one to one ,d+[DATE] times weekly as tolerated. Review of R44's activities program does not show any 1 to 1 activity provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and record review the facility failed to provide wound care as physician ordered. This applies to 1 of 6 residents (R74) reviewed for pressure ulcers. Findings include: R74 has diagnoses that include metabolic encephalopathy, lack of coordination, reduced mobility, malignant neoplasm of prostate and hypertension. R74's has a physician order to cleanse area to coccyx with wound cleanser, pat dry, apply calcium alginate and secure with border gauze daily. R74's current care plan states the R74 has an actual skin impairment of pressure ulcer to sacrum related to fragile skin with interventions that include treatment as ordered. On 5/16/24 at 10:54 AM R74 stated there is a wound on his backside. R74 stated he did not know how he developed the wound. R74 stated his dressing had only been changed once during the week. R74 did not remember what day it was changed. On 5/16/24 at 12:01 PM, V5 ADON (Assistant Director of Nursing) stated she did wound rounds on 5/14/24 for R74. V5 ADON stated a small opening was discovered on R74's sacrum on 5/12/24. V5 stated at that time the open area measured 0.5 cm x 0.5 cm (centimeters). V5 stated the order was for boarder gauze to be changed daily and as needed. V5 stated R74 was seen by the wound Doctor on 5/14/24 and the wound measured 0.8cm x 0.6cm x 0.1 cm. On 5/16/24 at 12:20 PM V5 ADON was observed changing the dressing for R74. The soiled dressing that was removed was dated 5/14. The dressing had a scant amount of brown drainage. R74's wound was a pea sized area with white slough with perimeter of redness approximately 1 inch. V5 stated it was the same dressing she had applied. V5 stated the nursing staff were supposed to have changed R74's dressing on 5/15/24. The facility policy Pressure Injury and Skin Condition assessment dated ,d+[DATE] states dressings will be checked daily for placement, cleanliness and signs of infection.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview and record review, the facility failed to provide a restorative range of motion program to a resident with limited range of motion. This applies to 1 of 1 resident (R33) reviewed for limited range of motion in a sample of 25. The findings include: On 05/14/24 at 02:23 PM R33 was in bed, awake, alert, and oriented x 1-2. R33's left leg was contracted. R33 complained of pain to his left thigh. On 05/16/24 at 12:14 PM V17 (Certified Occupational Therapy Aide/Director of Rehab) said R33 received occupational therapy and physical therapy beginning on 04/16/24. V17 said occupational therapy ended 05/02/04 and physical therapy ended 05/06/24. V17 said when R33 was discharged from therapy, the therapy department referred him to restorative nursing for lower extremity range of motion. On 05/16/24 at 01:39 PM V5 (Assistant Director of Nursing) said during the facility's morning meeting, therapy discusses who is coming off therapy. V5 said the facility does not have a restorative nurse, and the MDS (Minimum Data Set) department picks up on restorative. V5 said the floor nurses are responsible for putting the order in for residents to have PROM (Passive Range of Motion) or any other recommendations made from therapy. V5 said we have a restorative CNA (Certified Nursing Assistant) and she does the ROM (Range of Motion) and PROM on residents. V5 said V2 (Director of Nursing) tells the CNA the residents that needs to be seen. V5 said I do not have any documentation that R33 receives PROM. I was not aware that he had a referral for PROM from the rehab department. I am aware that his left upper extremity and left lower extremity is contracted. If we receive any recommendations, we are supposed to put the order in and follow through with the order. I do not see an order or task for PROM to R33's lower extremities. If recommendations were given for PROM, we should be doing PROM to his bilateral lower extremities. If he is not receiving PROM the contractures could get worse. I expect for the staff to follow the recommendations and complete the PROM. R33's Face Sheet showed R33 had diagnoses of unspecified sequelae of cerebral infarction, lack of coordination, abnormal posture, repeated falls, cognitive communication deficit, diabetes, ataxia, hemiplegia, and hemiparesis following cerebral infarction affecting left non dominant side, contusion of left hand, low back pain, benign prostatic hyperplasia without lower urinary tract symptoms, and contusion of left hip. R33's MDS dated [DATE] showed R33 had an impairment to both upper extremities and both lower extremities. R33's Progress Notes dated 04/29/24 showed R33 was seen by the Nurse Practitioner and the note stated R33 is at high risk for further decline. A progress note dated 04/25/24 showed R33 was seen by the same Nurse Practitioner and the note stated R33 was asked if he is open to performing stretching and ROM in his room. He stated he would be willing to try but only in his bed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's Restorative Observation dated 04/16/24 showed the IDT believes the resident would benefit from PROM restorative programs. The same observation showed R33 had paralysis/paresis of right upper extremity, right lower extremity, left upper extremity, left lower extremity. The observation stated R33 has an existing contracture or limited ROM. The facility's Rehab department referral date 05/06/24 recommended PROM to both lower extremities in supine or side lying position in available planes of motion as tolerated once per day three to five times per week as tolerated. The facility's Restorative Nursing Program Policy effective 11/2023 stated: Purpose- to promote each resident's ability to maintain or regain the highest degree of independence as safely as possible. Guidelines: *each resident will be screened for restorative nursing upon admission, annually, quarterly, and with any significant change in function. *appropriateness for a restorative program will be determined by the interdisciplinary team as needed and/or may be determined as a continuation of care following a course of physical, occupational and or speech therapy. *a licensed nurse supervises the restorative programs. *identify residents who currently have splints/braces or previous range of motion programs or those that have actual or potential limitations with ROM and/or pain. *if a resident is determined to be appropriate for a restorative program, no physician's order is needed. *range of motion programs may include active assisted range of motion, active range of motion, or passive range of motion.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Bradley	650 North Kinzie Ave Bradley, IL 60915

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48526 Based on observation, interview, and record review the facility failed to identify environmental hazards that poses risks for potential accidents. This applies to 6 of 6 residents (R6, R8, R28, R33, R39, and R61) reviewed for accidents/hazards in the sample of 25. The findings include: 1. On 05/14/24 at 12:20 PM R39 was not in the room. A portable oxygen tank (cylinder) was stored in R39's closet without a cart or stand. On 05/15/24 at 3:11 PM the portable oxygen tank (cylinder) was still in the closet without a storage cart or stand. On 05/16/24 at 10:44 AM the portable oxygen tank continued to be stored in R39's closet without a storage cart or stand. On 05/14/24 at 2:55 PM R39 said he does not use oxygen and does not know why the oxygen is stored in his closet. On 05/16/24 at 11:51 AM V5 (Assistant Director of Nursing) said the portable oxygen (cylinder) tanks are stored in the front oxygen room. The portable oxygen is stored in a crate that is individualized for each tank. No oxygen should be stored in a closet without being secured. V5 said secured means that the oxygen is in a holder. V5 said no oxygen should be stored in a residents room that does not have an order for oxygen and does not use oxygen. V5 said if unsecured oxygen falls on the floor, it can explode, and someone could get hurt. A fire can start and everyone in the area could be affected. V5 said the expectation is that all oxygen tanks are stored in the storage closet. R39's Face Sheet showed R39 had diagnoses of lack of coordination, abnormal posture, reduced mobility, chronic respiratory failure with hypoxia, diabetes mellitus with diabetic ophthalmic complication, diabetes with diabetic peripheral angiopathy without gangrene, asthma, angina pectoris, morbid obesity due to excess calories, chronic obstructive pulmonary disease, pulmonary fibrosis, rheumatoid arthritis, benign prostatic hyperplasia without lower urinary tract symptoms, bipolar disorder, depression, anxiety, obstructive sleep apnea, and hypertension. R39's MDS (Minimum Data Set) dated 02/23/24 showed R39 was cognitively intact. R39's Physician Orders showed no orders for oxygen. 2. On 05/14/24 at 12:19 PM R61 roommate of R39 was observed in his room where the oxygen was stored. R61's Face Sheet showed R61 had diagnoses of diabetes with diabetic neuropathy, unsteadiness on feet, obesity, atherosclerotic heart disease of native coronary artery without angina pectoris, osteoarthritis, left hip pain, chronic kidney disease, benign prostatic hyperplasia without lower urinary tract symptoms, and abnormalities of gait and mobility. 3. On 05/14/24 at 12:14 PM R33 was in his room, next door to where the oxygen was stored in the closet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R33's Face Sheet showed R33 had diagnoses of unspecified sequelae of cerebral infarction, lack of coordination, abnormal posture, repeated falls, cognitive communication deficit, diabetes, ataxia, hemiplegia, and hemiparesis following cerebral infarction affecting left non dominant side, contusion of left hand, low back pain, benign prostatic hyperplasia without lower urinary tract symptoms, and contusion of left hip. 4. On 05/14/24 at 12:12 PM R6 was in his room, next door to where the oxygen was stored in the closet. R6's Face Sheet showed R6 had diagnoses of dysphagia, lack of coordination, abnormal posture, reduced mobility, acute respiratory failure without hypoxia, pressure ulcer of sacral region, bipolar disorder, pleural effusion, unspecified intestinal obstruction, vein compression, spondylolysis, sciatica, benign prostatic hyperplasia with lower urinary tract symptoms, wedge compression fracture of T11-T12 vertebra, and wedge compression fracture of first lumbar vertebra. 5. On 05/14/24 at 12:08 PM R8 was in her room, across the hall from where the oxygen was stored in the closet. R8's Face Sheet showed R8 had diagnoses of lobar pneumonia, lack of coordination, reduced mobility, abnormal posture, morbid obesity, diabetes, acute respiratory failure with hypoxia, anemia, major depressive disorder, essential tremor, paroxysmal atrial fibrillation, pressure ulcer of right buttock, and weakness. 6. On 05/14/24 at 12:38 PM R28 was in the dining room. R28's room was across the hall from where the oxygen was stored in the closet. R28's Face Sheet showed R28 had diagnoses of pulmonary embolism, dysphagia, unsteadiness on feet, lack of coordination, abnormalities of gait and mobility, protein calorie malnutrition, chronic kidney disease, weakness, dementia, acute myocardial infarction, right shoulder pain, chest pain syncope and collapse, and displaced fracture of upper end of right humerus. The facility's Storage Policy for oxygen cylinders showed: *oxygen cylinders must maintain a minimum distance of 20 ft from combustibles (5 ft is room is sprinkled) or be placed within an enclosed cabinet having a fire rating of at least a half hour. *cylinders must be secured in racks or by chains.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on observation, interview, and record review, the facility failed to contain, replace, and date respiratory equipment. This applies to 4 of 4 residents (R5, R11, R15, R38) reviewed for respiratory equipment in a sample of 25. The findings include: 1. On 5/15/24 at 10:45 AM, during initial tour, surveyor went to R11's room. R11 was not in his room. On R11's end table, his face mask to his AVAPS (Average Volume Assured Pressure Support) machine was not dated or contained in a plastic bag. R11's POS (Physician Order Sheet) shows the following order: AVAPS: When sleeping maximum pressure 30 PS Min/Max 10/15 EPAP Min/Max 10/15 Rate: 20 Tidal Volume: 600 Insp. Time 0.88 2 liters oxygen. 2. On 5/15/24 at 11:15 AM, R15 was not in his room. His concentrator was left on. R15's oxygen tubing was not dated. R15's nasal cannula was uncontained and left on his recliner. R15's POS shows the following order: Oxygen per Nasal Cannula at 2 Liters/Minute continuous every shift related to unspecified chronic bronchitis. 41384 3. On 05/14/24 at 1:55 PM, R38's nasal cannula, BIPAP mask, & nebulizer mask was not covered, and her 02 humidifier container was dated 4/21/24, (23 days later). R38's 5/6/24 orders showed change out, date, and label O2 humidifier every Sunday. On 05/16/24 at 11:37 AM V1 (Administrator) said that respiratory equipment, BIPAP masks, nasal cannulas, and nebulizer masks should be in plastic bags for infection control purposes. The facility's policy, Oxygen & Respiratory Equipment - Changing/Cleaning (date 1/2019) showed, the purpose is to minimize the risk of infection transmission. Nasal cannulas, handheld nebulizers, and BIPAP masks should be stored in a clean plastic bag with a zip lock or drawstring, marked with a date the setup was changed. Oxygen humidifiers shall be changed weekly or as needed and will be dated when changed. 34410 4. R5 is a [AGE] year-old female with mild cognitive impairment as per the Minimum Data Set (MDS) dated [DATE]. R5 is admitted with an admitting diagnosis including acute and chronic acute respiratory failure, chronic obstructive pulmonary disease, and obstructive sleep apnea. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 at 11:42 AM, R5 was observed in her room with nasal cannula on. Observed a nebulizer mask, not contained in a plastic/zip lock bag, hanging from the bedside drawer and C-PAP mask on the table without containing. On 5/15/24 at 10:24 AM, V5 (Assistant Director of Nursing/ADON) stated, The respiratory equipment including nebulizer mask and C-Pap mask should be stored in a plastic zip lock bag.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46003 Based on observation, interview and record review the facility failed to provide adequate staffing to meet the care needs of residents. Staffing was insufficient to provide residents with assistance in Activities of Daily Living, a dignified dining experience and answering of call lights. This applies to 11 residents (R5, R9, R16, R18, R22, R24, R29, R32, R38, R46, R51) reviewed for staffing concerns in a sample of 25. Findings include: On 5/14/24 at 9:45 AM, a strong stench of urine was noted upon entry into the facility. On 5/15/24 at 02:08 PM, during the Resident council meeting 1. R51 stated there are only four C.N.As (Certified Nursing Assistant) for the entire facility at nights. R51 stated staffing for the facility is terrible nights and weekends. R51 stated they hear residents calling out for help every night and weekends. 2. R38 stated there are only four C.N.A at nights and on weekends and two nurses at night. R38 stated staffing is short on weekends. R38 stated staff see her at the end of the shift like she is an afterthought. R38 stated she did not like that the facility smelled of urine but did not think anything could be done about incontinent residents. 3. R16 stated there is not enough help for the residents. R16 stated it takes staff too long provide him assistance. 4. R46 stated the facility smells because residents aren't receiving incontinence care. On 5/16/24 at 11:02 AM, V19 C.N.A stated her residents don't appear to have received catheter care when she is off. On 5/16/24 at 11:50 AM, V20 C.N.A. stated there have been mornings she has come in to find residents soaked in urine and soiled with stool. V20 stated staffing is short when agency staff leave early or don't show up. Sometimes the staff is not replaced. On 5/16/24 01:52 PM, V18 C.N.A / Staffing Scheduler stated the C.N.A at night has 19 residents each. V18 stated that is not a lot of residents because they are just supervising. The night C.N.As don't do cares at night they just watch the residents and do not provide incontinence care. Night shift C.N.As only have to get up three residents each morning. V18 stated she has had staff complain they need more staff. V18 stated staff have complained to her that residents are super saturated with urine and have not been changed. V18 stated the complaints are usually on weekends behind agency staff. On 05/16/24 at 2:18 PM, V5 ADON (Assistant Director of Nursing) stated night shift staff are expected to reposition and provide incontinence care to all residents that require it every two hours. V5 stated even residents that are independent should be checked on every two hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	34410 5. R299 is a [AGE] year-old female with severe cognitive impairment as per the Minimum Data Set (MDS) dated [DATE]. The MDS also documents that R299 requires partial/moderate assistance with eating. 6. R18 is a [AGE] year-old male with cognition intact as per the MDS dated [DATE] and requiring substantial/maximal assistance for eating. 7. R22 is a [AGE] year-old male with severely impaired cognition as per the MDS dated [DATE] and with an admitting diagnosis, including hemiplegia affecting the right dominant side secondary to cerebral infarction. 8. R24 is a [AGE] year-old female with severely impaired cognition as per the MDS dated [DATE] and requiring partial/moderate assistance for eating. On 5/15/24 at 12:25 PM, observed seven residents (R299, R18, R22, R24, R48, R27, and R62) around a dining table during lunch. Observed R299, R18, R22, and R48 were not fed while V11 (MDS coordinator) was feeding R48, V12 (Certified Nursing Assistant/CNA) was feeding R27, and V13 (CNA) was feeding R62. On 5/15/24 at 12:30 PM, R18 stated, - I want to eat. I am hungry. On 5/15/24 at 12:30 PM, V11 stated, We are on the way to feed remaining residents. On 5/16/24 at 10:05 AM, V5 (Assistant Director of Nursing/ADON) stated, The residents should have a dignified feeding experience. They should have called for more staff to feed those not fed and watch feeding other residents. 9. R9 is a [AGE] year-old female admitted on [DATE] with moderately impaired cognition as per the minimum data set (MDS) dated [DATE]. MDS also indicates that R9 requires substantial/maximal assistance on toilet hygiene. On 5/14/24 at 11:30 AM, the writer observed R9's room with intense urine/feces smell. In response to this writer's request V8 (Certified Nursing Assistant/CNA) checked on R9 and found with thick watery bowel movement with stool smeared all around perinium up to below her abdominal fold. On 5/14/24 V8 stated that she checked R9 at 6:15 AM and they are supposed to check on residents for incontinent care every two hours. On 5/15/24 at 10:24 AM, V2 (Director of Nursing/ DON) stated that incontinent care should be provided every two hours and as needed. A review of R9's bowel and bladder incontinent care plan document: Check and change x 3 times every shift and as required. Wash, rinse, and dry perineum. 41384 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On 05/14/24 at 12:41 PM, R29 was observed with long jagged nails and facial hair on her chin, about 1/2 inch long. On 05/15/24 at 12:14 PM R29 was observed with long jagged nails and facial hairs on her chin. R29's 5/21/24 care plan showed R29 had an ADL self-care/mobility performance deficit that may fluctuate with activity throughout the day. R29's 3/20/24 MDS (minimum data set) section GG showed under personal hygiene that R29 was dependent for personal hygiene. On 05/16/24 at 10:44 AM V1 (Administrator) said that R29 should not have had facial hair and her nails should have been maintained for dignity, hygiene and self-feeling good and safety. V1 said R29's jagged nails could cause her to scratch herself or someone else. 11. On 05/14/24 01:45 PM R32 was observed with facial hair on both sides of her mouth up to 2 inches in length. R32 was asked how she felt about the facial hair and her reply was that she felt neglected. R32 said that staff does not want to help her shower when she requests it. R32 said that she smells, and that she doesn't get showers when she asks. R32's 2/13/24 MDS (minimum data set) section GG showed under personal hygiene, needs supervision or touching assistance and under Bathing needs partial moderate assistance. R32's 5/7/24 care plan showed R32 has and an ADL self-care/mobility performance deficit that may fluctuate with activity throughout the day. R32's electronic health records under Task showed for the last 30 days for Shower/Bathe - No documentation, and for the last 30 days of, Bathing Tuesday and Friday PM showed only 4 days of documentation (5/3/24, 5/7/24 & 5/10/24). On 05/16/24 at 11:02 AM, V1 (Administrator) said that R32 should receive a shower or bed bath as needed or according to her care plan. The facility's Morning Care policy dated 01/2018 showed that the purpose is to promote comfort, cleanliness and dignity. The facility's Nail Care policy dated 01/2018 showed observe condition of resident's nails during each time of bathing. Note cleanliness, length, uneven edges.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 31327 Based on observation, interview, and record review, the facility failed to: wear appropriate PPE (Personal Protective Equipment) when going into an isolation room, monitor and track residents who were on isolation, obtain physician orders for isolation, develop care plans for isolation, and perform hand hygiene during wound care. This applies to 4 of 4 residents (R17, R21, R31, R62) reviewed for infections in a sample of 25. The findings include: On 5/15/24 at 11:24 AM, V5 (Registered Nurse/Assistant Director of Nursing/Infection Preventionist) stated, I work full time here. I started in August in 2023. The facility's last annual survey was in April 2023. I don't have a separate logbook of residents who were on isolation since then. I didn't know we were supposed to log those. Surveyor asked V5 who was on isolation currently. She stated that R62 was the only resident on isolation. When asked who were the residents that were on isolation for the past couple of months, V5 could only remember two other residents-R21 and R31 because she never created any logs for residents were on isolation precautions. 1. On 5/15/24 at 11:15 AM, R62 was sitting in his reclined chair outside of his room. V7 (Housekeeper) was mopping R62's floors in his room. She was not wearing gown and gloves when cleaning his room. On 5/15/24 at 11:30 AM, V5 stated, (R62) has ESBL (Extended Spectrum Beta Lactamase) in the urine. He can come out of his room as long as his catheter is contained and he's not urinating all over. But (V7) should have followed the guidelines and worn the appropriate PPE. (R62) has ESBL in the urine, which is contact precautions. (V7) should have worn gowns and gloves before entering that room. What if there is urine on the bed or floor? She could have come in contact with it. R62's lab results report dated 4/5/24 show that he tested positive for ESBL. R62's progress notes document the following: On 4/4/24 at 1:19 PM, This resident's urine is positive for ESBL. Nurse Practitioner ordered IV (Intravenous) Ertapenem q 24 hours for 1 week via midline access. Notified brother of (R62) and gave verbal consent via phone to insert a midline access. Placed an order with the lab company. On 5/4/2024 at 11:11AM, Received resident UA (Urinalysis) C&S (Culture & Specimen) results with positive for ESBL. This nurse telephoned resident (Medical Doctor) and discussed resident's results. Received telephone order to give resident Amoxicillin 875 mg PO for 14 days, then repeat UA C&S, refer to Infectious Disease MD Dx Recurrent ESBL in the urine. This nurse notified (R62's) brother. DON (Director of Nursing) notified. Review of R62's POS (Physician Order Sheet) shows there is no order for isolation and contact precautions and no care plans. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 5/15/24 at 11:40 AM, V5 stated, (R31) had ESBL in the hospital. He was readmitted to us with that diagnosis. The doctor put him on Ertapenem 500 MG (Milligrams) for 12 days. I don't understand why there's nothing mentioned in his progress notes about his isolation or the ESBL. The admitting nurse didn't document anything that he was on contact precautions or had ESBL. I remember I got the signs out for contact precautions and put in on his door. He was in isolation. There are no orders for the isolation and there is no care plan. I don't know what happened. I don't have a log of resident infections or isolations. R31's Transfer form from hospital dated 3/11/24 documents: Isolation type: contact. Isolation precautions--ESBL. Facility's March 2024 POS shows no orders for contact isolation for ESBL. R31's McGeer's criteria dated 3/11/24 shows Ertapenem 500 mg daily x 12 days--complicated UTI (Urinary Tract Infection), ESBL. R31's progress notes show that on 3/4/24, His left side nephrostomy tube is leaking upon assessment. Notified doctor and ordered to send to hospital. On 3/11/24, (R31) was readmitted back to facility. Nothing was mentioned in the progress notes about ESBL or contact precautions. R31's infection charting notes do not mention anything about ESBL. R31's care plans didn't document anything about the ESBL or isolation. 3. R21's transfer report dated 4/9/24 from the hospital shows he had MRSA (Methicillin Resistant Staphylococcus Aureus) and ESBL in the urine. Progress notes show he went to the hospital for a schedule procedure on 4/8/24. Nursing notes document the following: On 3/29/23 at 10:00 PM-Received culture result from lab. Positive for ESBL to right flank wound. Ordered Bactrim DS twice a day x 7 days. Referral to ID (Infectious Disease). (R21) placed on contact isolation. POA (Power of Attorney) update. Will continue to monitor. On 4/9/24 at 5:10 PM, (R21) returned from the hospital. Vitals stable. No new order. R21's POS for March 2024 and April 2024 do not show any isolation orders for MRSA and ESBL. R21's care plans do not document anything regarding isolation, MRSA, and ESBL V5 confirmed that R21 did not have any isolation orders or care plans developed. (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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 31327 Based on interview and record review, the facility failed to utilize a standardized tool to determine the necessity of antibiotics prescribed to residents. This applies to 6 of 6 residents (R11, R25, R38, R47, R58, R60) reviewed for antibiotics in sample of 25. The findings include: 1. R11's POS (Physician Order Sheet) shows Amoxcillin-Potassium Clavulanate Tablet 875-125 MG (Milligrams): 1 tablet by mouth every 12 hours for infection for 7 days with an order date of 8/3/23. The August Monthly Infection Log shows the following for R11: Infection site: skin (ssti) left lower leg; Onsite date of 7/27/23; Signs/Symptoms: Left lower leg swelling erythema (+) drainage. Lab/Diagnostic Results Wound Culture/ MRSA (Methicillin-resistant Staphylococcus aureus) and VRE (Vancomycin Resistant Enterococci). R11 did not have a McGeer's criteria form in the infection control binder or uploaded into his electronic medical record. 2. R25's POS shows Ciprofloxacin HCL 500 MG: Give one tablet by mouth every 12 hours for UTI (Urinary Tract Infection) for 5 days with an order date of 9/7/23. The September Monthly Infection Log shows the following for R25: Infection site--UTI, Onset date: 9/7/23, Sign/symptoms: Change in mental status, tea colored urine, lag/diagnostic results--urine culture + nitrates. R25 did not have a McGeer's criteria form in the infection control binder or uploaded into her electronic medical record. 3. R38's POS shows Ciprofloxacin HCL Tablet 500 MG: Give 1 tablet by mouth one time a day for UTI/Infection for 5 days with an order date of 8/4/23. The August Monthly Infection Log shows the following for R38: Infection site--UTI, noncatheter, Onset date: 7/31/23; Signs/symptoms: Dysuria, lab results--urinalysis E.coli >100,000. R38 did not have a McGeer's criteria form in the infection control binder or uploaded into her electronic medical record. 4. R47's POS shows an order date of 7/11/23 with the following order: Moxifloxacin HCL Ophthalmic Solution 0.5% --Instill 1 drop in both eyes 3 times a day for eye infection secondary to MRSA for 7 days until finished. Apply to both eyes. Keep order active until eye infection is resolved. The July 2023 Antibiotic Stewardship log shows a start date of 7/12/23 for Moxifloxacin HCL Ophthalmic Solution 0.5% and end date of 719/23; Agent--Routine, order for antibiotic. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146112	A. Building B. Wing	05/17/2024

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R47 did not have a McGeer's criteria form in the infection control binder or uploaded into his electronic medical record. 5. R58's POS shows Ciprofloxacin HCL tablet 500 MG--Give 1 tablet by mouth every 24 hours for infection for 5 days with an order date of 3/27/24. The March Monthly Infection Log shows: Infection site--urinalysis, Facility acquired--no mcgreer's criteria, Symptom onset date 3/37/24, Symptoms: Burning and itching, Culture results--urinalysis/culture. R58 did not have a McGeer's criteria form in the infection control binder or uploaded into her electronic medical record. 6. R60's POS shows Doxycycline Monohydrate Oral capsule 100MG--1 capsule my mouth two times a day for infection for 1 day and give 1 capsule by mouth one time a day for infection for 7 days with an order date of 2/12/24. The February Monthly Infection Log shows: Infection site--skin, Facility acquired, Symptom onset: 2/12/24, Signs/symptoms: Red irritated lump under armpit, no culture done. R60 did not have a McGeer's criteria form in the infection control binder or uploaded into his electronic medical record. On 5/15/24 at 11:24 AM, V5 (Registered Nurse/Assistant Director of Nursing/Infection Preventionist) stated, I work full time here. I started in August in 2023. Corporate reminded me that the nurses were supposed to fill it out, but they were not doing it. It's both the nurse and my responsibility to do the McGeer's criteria. We need to do the McGeer's criteria because we want to make sure the residents are not getting the wrong antibiotics. They don't need too much antibiotics and we don't want them to get resistance. We have to wait for the lab results first and then administer the antibiotics. I can't find the antibiotic log sheets for October and November 2023. I'm not sure what happened to them. Facility's policy titled Infection Prevention and Control Program (3/2024) shows 15. All facility personnel should adhere to the Infection Control Program in the performance of their daily assignments. Facility's policy title Antibiotic/Antimicrobial Stewardship Program-Mission Statement and Guidelines (11/2023) shows: 5. Tracking-Monitor at least one process measure of antibiotic use and at least one outcome from antibiotic use. This facility utilizes the McGeer's Criteria for determining if an infection meets criteria for treatment with an antibiotic. Facility's policy titled Infection Surveillance, Tracking and QA Reporting (11/2023) shows: Infection tracking includes but is not limited to: Review documentation of clinical signs and symptoms to determine if McGeer's criteria for infection were met and antibiotic use is appropriate.