STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146121	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benton Rehab & Hcc	1409 North Main Street Benton, IL 62812

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on Interview and Record Review, the facility failed to provide Advanced Beneficiary Notice of Non-Coverage (Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage/ SNFABN-CMS10055) for 2 of 3 residents (R2 and R26) reviewed for Beneficiary Protection Notification in the sample of 28. The findings include: 1. R2's face sheet documents diagnoses including: Hypertension, Hyperlipidemia, Anxiety Disorder, Depression, and Asthma. R2's face sheet documents an admitted [DATE]. R2's SNF Beneficiary Protection Notification Review form documents a discharge from Medicare Part A services prior to exhaustion of his benefit day allotment and a last covered day of Part A Services of 12/15/23. This form documents that a written notice of the resident's potential liability for a non-covered stay (SNFABN - CMS10055) form was not provided to R2 to explain her right to appeal the decision of discharge from Medicare Part A services prior to exhaustion of her benefit days. On 04/10/24 at 1:45 PM, V3 (Regional Consultant) stated they do not have the form (SNFABN - CMS 10055) for R2, it must have been missed. R2's record review does not contain a ANFABN - CMS 10055 document. On 04/10/24 at 2:45 PM R2 stated, she does not remember if she received any forms about her therapy days. 2. R26's face sheet documents diagnoses including: left hip fracture, Duodenal ulcers, and Atherosclerosis. R26's face sheet documents an admitted [DATE]. R26's SNF Beneficiary Protection Notification Review form documents a discharge from Medicare Part A services prior to exhaustion of his benefit day allotment and last covered day of Part A Services of 1/19/24. This form documents that a written notice of the resident's potential liability for a non-covered stay (SNFABN - CMS10055) form was not provided to R26 to explain her right to appeal the decision of discharge from Medicare Part A services prior to exhaustion of her benefit days. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 1:45 PM, V3 (Regional Consultant) stated they do not have the form (SNFABN - CMS 10055) for R26, it must have been missed. R26's record review does not contain a SNFABN - CMS 10055 document. On 04/10/24 at 2:40 PM R26 stated, she does not remember if she received any forms about her therapy days.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview and record review, the facility failed to obtain the Pre-Admission Screening and Resident Review (PASRR) document for 1 of 5 resident (R29) reviewed for PASRR screening in a sample of 28. Findings include: R29's New admission Information Sheet (undated) documents an admitted [DATE] with diagnoses including Cerebral Vascular Accident (CVA), Acute right middle cerebral artery cerebral infarction, Left Hemiparesis, Hypertension, Left bundle Branch, Hyperlipidemia, Diabetes Mellitus type 2, Seizure disorder, Chronic Obstructive Pulmonary Disease (COPD), history of tobacco use, Chronic post traumatic headache, wasting syndrome, drug dependence, depression, anxiety, Post Traumatic Stress Syndrome, and occlusion of both carotid arteries. R29's Minimum Data Set (MDS) dated [DATE] documents in Section C, a Brief Interview for Mental Status (BIMS) score of 11, indicating that R29 has moderate cognitive impairment. Section GG of the same MDS documents eating as not attempted due to medical condition, R29 is dependent with toileting and positioning, and R29 requires substantial/ maximal assistance with bathing, and upper and lower body dressing. R29's Care Plan dated 03/08/24 documents problem of resident/family agree resident is not a candidate for discharge due to extensive nursing care required. The same Care Plan documents a Goal of resident/family will express dialogue for discharge, will be available with Social Service Director (SSD) and/or Director of Nursing if needed at least quarterly. Documented interventions include in part- review continued placement quarterly/annually per resident wishes and review discharge potential for changes quarterly. On 04/08/24 at 1:04PM, V22 (Business Office Manager/BOM) stated that she had not completed a PASRR screening on R29. V22 stated that R29 was admitted from out of state and she forgot about submitting a PASRR level 1 screening. V22 stated that she has submitted the request now. V22 stated that she knows that R29 was recently admitted on [DATE]. R29's Pre-Admission Screening document obtained by surveyor on 04/08/24 from V22(Business Office Manager/BOM) and dated 04/08/24, documents that R29 has no mental health diagnoses, No substance related diagnoses, no dementia/neurocognitive disorders and documents PASRR Level I reviewer : Web-approved and PASRR level I determination: No level II required with a review date of 04/08/24. On 04/11/24 at 11:00AM, V3(Regional Consultant) stated that they do not have a policy on conducting PASRR's.

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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 - 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** 44492 Based on interview, observation, and record review, the facility failed to implement interventions to prevent and treat a pressure ulcer for 1 of 3 residents (R1) reviewed for pressure ulcers in a sample of 28. The findings include: R1's Profile Sheet documents that R1 was admitted to the facility on [DATE] with diagnoses including mixed receptive-expressive language disorder and unspecified intellectual disability. R1's Minimum Data Set (MDS) dated [DATE] documents Section C, Cognitive Skills for Decision Making, severely impaired-never/rarely/made decisions. Section GG, Functional Abilities and Goals, of the same MDS documents that R1 is dependent with eating, oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/off footwear, personal hygiene, bed mobility, and transfers. R1's Care Plan undated, documents Problem/Need of: High Risk for Pressure Ulcer per Braden Risk Assessment, incontinence, limited mobility, dependent on staff for meeting all needs, prone to skin tears, and Braden Risk Score high; 10/4/2023 documents wThereound to coccyx daily see Physician's Order Sheet (POS). R1's Care Plan documents a Goal of: Will have no new open areas caused by pressure or friction through next review date 6/12/2024. R1's Care Plan documents an Approach/Intervention of: Skin risk assessment: Braden Scale weekly x 4 weeks upon admission or readmission and then quarterly; Braden scale score 11 (High Risk) - skin check daily with documentation and as needed with any new open area; pressure relieving device in wheelchair; pressure relief mattress in bed; apply house stock skin cleanser to peri-area with every after incontinent episode and as needed. Toilet/change brief when wet and upon rising, at bedtime and after meals; Lotion skin with cares and as needed, avoid friction over boney prominences; Maintain clean, dry, wrinkle free linens; Keep fluids at bedside (prepare at ordered consistency) and offer during cares unless contraindicated. Encourage fluid consumption at meals; Assess skin - if open or bruised areas noted, report to primary physician and responsible party; Prevent skin area from prolonged contact. Use pillows, place padding between legs, etc.; Wound physician to see as needed; treatments as needed with a start date of 6/21/2014; Treatment as ordered to area on sacrum; Wound physician to evaluate and treat with a start date of 10/4/2023. R1's Braden assessment dated [DATE] documents score is 13, indicating R1 is a High Risk for skin breakdown. There was no March 2023 Braden Assessment located in R1's medical record. On 4/9/2024, at 12:50 PM, R1 was observed lying in his bed on his right side with pillows positioned around him with bilateral heels not floated. On 4/9/2024, at intermittent observations at 1:15 PM, 1:50 PM, 2:15 PM, 3:00 PM, 3:15 PM, and 3:45 PM, R1 was observed lying in his bed on his right side with pillows positioned around him with bilateral heels not floated. On 4/10/2024, observations made at 7:30 AM and 8:30 AM, R1 was observed sitting upright in his geri-chair in the dining room in the same position. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/2024, intermittent observations made at 9:00 AM, 9:15 AM, 9:30 AM, 10:00 AM, 10:20 AM, 10:45 AM, and 11:00 AM, R1 was observed sitting upright in his geri-chair in his room in the same position. On 4/10/2024, intermittent observations made at 11:15 AM, 11:30 AM, 11:45 AM, 12:00 PM, and 12:15 PM, R1 was observed sitting upright in his geri-chair in the dining room in the same position. On 4/10/2024, at 12:30 PM, R1 was observed lying in his bed on his right side with pillows positioned around him and bilateral heels not floated off bed. On 4/10/2024, at 12:50 PM, V9 (Licensed Practical Nurse/LPN), with assistance by V10 (Certified Nurse Aide), was observed performing incontinence care on R1. R1's upper right sacrum area was observed to have a small open area, with redness and no drainage or signs and symptoms of infection noted. R1's bilateral heels were observed and both heels were intact. O 4/10/2024, at 12:55 PM, V9 (LPN) stated that area to R1's sacrum area is the same area that opens frequently and heals up. V9 stated that R1 does not currently have a treatment to his sacrum area. V9 stated that she will call R1's primary physician and get a treatment order for his open area and ask the primary physician if R1 can get a consult to see the wound physician for evaluation and treatment. On 4/10/2024, at 1:20 PM, V2 (Director of Nursing) stated that it is her expectation of her nursing staff to know what residents are at high risk for pressure ulcers or skin areas and she expects her nursing staff to utilize preventative measures of heel protectors, turn and reposition at least every two hours, offloading heels, etc. to help prevent pressure areas. V2 stated that if a nurse or CNA notices an open area on a resident, it is her expectation for her nursing staff to report it to the nurse and the nurse to report it to the primary physician and get an immediate order in place to treat the open area as soon as possible. V2 stated that it is the expectation that the nurse assesses the area and get measurements of the area. V2 stated that every wound is monitored weekly. V2 stated that wounds are discussed weekly with the other management staff. V2 stated that she reviews new physician's orders, any treatments, and keeps a wound log of current wounds. On 4/10/2024, at 2:00 PM, when asked how often R1 should be turned and repositioned, V14 (CNA) and V11 (CNA) both stated that R1 should be turned and repositioned every two hours. When asked if there was a reason that R1 was not turned and repositioned every two hours during the morning hours, V11 stated that she got busy and forgot about repositioning or laying R1 down and V14 (CNA) stated that R1 is supposed to lay down after meals. On 4/10/2024, at 3:00 PM, V23 (Wound Physician) stated that he saw R1's open area to his right upper sacral and it is caused by shearing, moisture-associated skin damage (MASD) and is a recurring area for him. V23 stated that R1 gets a treatment for it, and it heals up rather quickly for him. R1's Treatment Administration Record (TAR) for 2/01/2024 through 2/29/2024, documents treatment to coccyx discontinued on 2/21/2024. R1's TAR for 4/03/2024 documents weekly skin check with no new areas noted. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Decubitus Care/Pressure Areas policy dated 1/2018 documents Policy - It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation, and record review the facility failed to provide physician ordered nutritional supplements to 2 of 5 (R1 and R4) residents reviewed for nutrition in a sample of 28. Findings include: 1. R1's Profile Sheet documents R1 was admitted to the facility on [DATE] with a diagnosis of mixed receptive-expressive language disorder, unspecified intellectual disabilities. R1's Minimum Data Set (MDS) dated [DATE] documents Section C, Cognitive Skills for Decision Making, severely impaired-never/rarely/made decisions. R1's Physician Order Sheet dated 04/01/24 documents nutritional shake TID (three times a day), 7:00 AM, 12:00 PM, and 5:00 PM with an order date of 03/23/23. On 04/08/24 between 11:15 AM and 1:00 PM, R1 did not receive a nutritional shake during lunch service. On 04/08/24 at 12:30 PM, V7 (Dietary Manager) stated everyone has been served. On 04/09/24 between 11:30 AM and 12:30 PM, R1 did not receive a nutritional shake during lunch service. On 09/09/24 at 12:30 PM, V7 stated everyone has been served. On 04/10/24 at 2:10 PM V7 stated they did not have the nutritional shakes on 04/08/24 and 04/09/24 but the residents should have received something in place of the shake. On 04/10/24 at 2:30 PM, V7 stated the nutritional supplements are given out by the dietary staff. 48356 2. R4's Profile Face Sheet dated 02/10/24 documents R4 has an admitted [DATE] Diagnosis documents Chronic Obstructive Pulmonary disease (COPD), History of cellulitis, Psychosis, depression, Gastroesophageal reflux disease (GERD), Pulmonary Artery Disease (PAD), Chronic Kidney Disease stage 2, Major Depression, Peripheral Vascular Disease (PVD), Coronary Artery Disease (CAD), panic attacks, obesity, seasonal allergies, History of COVID, History of shortness of breath, history of shortness of breath, history of tracheostomy, History of gastroesophageal tube, Insomnia, left leg venous ulcer, sleep apnea, inability to care for self. R4's Minimum Data Set (MDS) dated [DATE] documents under Section C that R4 has a BIMS (Brief Interview for mental status) score of 10 which indicates R4's cognition level is moderately impaired. Section GG documents R4 requires set-up and clean up assistance with eating. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's undated Care Plan with a goal date of 06/12/24 documents a problem of potential risk for altered nutritional status and or weight loss related to diagnosis weakness. Goals is resident will not loose significant amount of weight times next 90 days. Intervention include in part- provide diet as ordered, encourage self-feeding, provide ample time to eat. R4's weight records document 01/2024 weight 156, 02/2024 169, 03/2024 166, 04/2024 167. R4's Physician Orders dated 04/01/24 to 04/30/24 documents an order for Nutritional Shake two times a day given by kitchen on tray ordered on 08/30/23. On 04/08/24 at 12:27 PM and on 04/09/24 at 11:58 AM during the lunch meal R4's was not noted to have a nutritional shake on R4's tray. On 04/10/24 at 2:10 PM, V7 (Dietary Manager) stated that they did not have nutritional shakes in the facility on 04/08/2024 or on 04/09/24 until after lunch meal was served. V7 stated that the truck with supplies such as the nutritional shakes did not come in until 04/09/24 after the 12:00 PM. V7 said that the nurses should of gave the R4 (name of nutritional supplement) instead of the nutritional shake since they didn't have any. V7 said that R4's nutritional shakes did get discontinued on 04/09/24 after 12:00 PM. V7 said that R4 said that he didn't want the nutritional shakes no more because he was gaining weight. V7 stated that the doctor discontinued the order per R4's request. On 04/10/24 at 2:15PM, V9 (Licensed Practical Nurse (LPN) stated that R4 is supposed to get his nutritional shake from the kitchen. V9 said that she was not aware if R4 got his nutritional shake on 04/08/2024 or 04/09/24 at lunch meal. V9 stated that R4 does not get (name of nutritional supplement) and that he has never received any supplement from her. V9 stated that she worked on 04/08/24 and 04/09/24 during lunch meal. The facility policy dated 10/13 documents: Nutrition Supplements and Nourishments: It is the policy of (facility name) to provide additional calories and/or to residents who cannot and/or are not capable of consuming adequate nutrients through their regular meals. It is also the policy of (facility name) to provide guidelines for the selection, ordering, use and monitoring of nutrition supplements and nourishments.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview and record review, the facility failed to ensure placement was checked to enteral feeding prior to administering flush and feeding for 1 of 1 resident (R29) reviewed for enteral feedings in a sample of 28. Findings include: R29's New admission Information sheet, undated documents an admitted [DATE] with diagnosis of Cerebral Vascular accident (CVA), Acute right middle cerebral artery cerebral infarction, Left Hemiparesis, Hypertension, Left bundle branch, Hyperlipidemia, diabetes mellitus type 2, seizure disorder, chronic obstructive pulmonary disease (COPD), history of tobacco use, Chronic post traumatic headache, wasting syndrome, drug dependence, depression, anxiety, Post Traumatic Stress syndrome, occlusion of both carotid arteries. R29's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief interview for mental status score of 11. Which indicated that R29 has some cognitive impairment. Section GG documents eating as not attempted due to medical condition, toileting and positioning as dependent. Bathing, upper and lower body dressing as substantial/maximal assistance. R29's Care Plan dated 03/08/24 documents problem of Peg tube with jevity with a goal of maintain weight and tolerates tube feeding. Interventions include in part. Enhanced barriers precautions dated 04/08/24, give Jevity per orders, consult with dietician, flush as ordered, clean site and dressing per orders. R29's Physician orders for 04/01/24 to 04/30/24 document Jevity 1.5 give 1 can 5 times daily, flush with 50ml (milliliters) water before and after each bolus ordered 03/12/24, Flush tube with 80ml water two times a day ordered on 03/12/24, Enhanced Barrier Precautions ordered on 04/08/24. Nothing By Mouth(NPO), tube feeding ordered on 03/01/24. On 04/10/24 at 10:31AM, V9 (Licensed Practical Nurse) went into R29's room to give feeding. V9 did not place any personal Protective Equipment on prior to entering R29's room. R29's room has sign that states Enhanced Barrier Precautions on door. V9 placed gloves on and administered 50ml of water via gastroesophageal tube (G-Tube) without checking placement of G-tube prior to administering water. V9 then administered the feeding without checking placement again. V9 then flushed after the feeding and no placement was checked. No personal protective equipment other then gloves were used during feeding. 04/10/24 at 1:15PM, V9 stated that she usually only checks G-tube placement once daily usually in the morning. V9 stated that she checks placement of the G-tube by putting 10-15cc of air into the tube via a syringe and she listens for a whooshing sound. V9 stated that if she didn't hear the whooshing sound she would call the doctor and not administer the feeding or flush. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 03:49 PM, V2 (Director of Nursing) stated that G-tube placement should be checked prior to feedings. V2 stated she didn't know how often R29's G-tube placement checks were ordered. V2 stated that if there was no order on how often it should be done on the Physician order sheets then V2 said it should be done anytime you do anything with the G-tube. V2 stated that she did not know the facility policy for checking placement of G-tube. V2 stated that the way she knows how to check placement is put water in the G-tube and listen to ensure placement. V2 stated that staff should probably be wearing Personal Protective Equipment (PPE) while administering a feeding via G-tube, but she wasn't sure. The facility's policy titled Enteral Feeding revised 02/08 documents, It Is the policy of (facility company) to provide commercially prepared products for enteral feedings via a nasogastric, G-tube, Jejunal Tube (J-Tube), or Percutaneous endoscopic gastrostomy (PEG) tube when it has been determined that oral feeding are not sufficient to meet physical requirements and the resident/responsible party and physician deem enteral nutritional support is appropriate. Purpose: To ensure a safe, nutritionally appropriate product which provides a source of complete nutrition in the form that will pass through a tube into the digestive system and which will maintain nutritional status as designated Procedures included in part Placement of tube will be confirmed via aspiration of residual. If unable to confirm placement via aspiration, air instillation method may be used, placement will be confirmed- prior to initiating a flush, prior to instillation of flush/medication administration, prior to initiating new feeding and/or adding product to an already infusing product, minimally every 6 hours if product infuses continuous, after episodes of vomiting or suctioning which may increase abdominal pressure or compromise tube placement, and as needed (PRN) when clinical indication of tube placement is suspect.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44492 Based on interview and record review, the facility failed to provide the services of a Registered Nurse for 8 consecutive hours per day/ 7 days a week. This failure has the potential to affect all 30 residents residing in this facility. The findings include: On 4/10/2024, at 2:30 PM, V2 (Director of Nursing) confirmed that they only have 1 Registered Nurse on staff. V2 stated that there was another registered nurse working in the facility but resigned last week. V2 stated she does not work the floor. V2 stated that the facility is working on hiring more registered nurses. V2 stated that the facility utilizes an outside agency to help maintain Registered Nurse (RN) coverage for 8 consecutive hours per day. Review of the Nursing Schedules from October 1st, 2023 through April 11, 2024 documents no RN coverage was provided at the facility on 10/1/23, 10/6/23, 10/7/23, 10/8/23, 11/17/23, 11/18/23, 11/19/23, 12/29/2023, 2/29/24, and 4/04/2024. On 4/08/2024, at 8:30 AM, observed V2 (DON) working in the facility. On 4/09/2024, at 8:30 AM, observed V23 (Agency RN) working in the facility. On 4/10/2024, at 8:00 AM, observed V24 (Agency RN) working in the facility. On 4/11/2024, at 8:00 AM, observed V2 (DON) working in the facility. The Resident Census and Conditions of Residents, dated 4/08/2024, documents the current census is 30.

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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** 32765 Based on observation, interview, and record review the facility failed to provide a menu that met residents nutritional needs for 1 of 1 (R16) residents reviewed for nutrition in the sample of 28. Findings Include: R16's Profile Face Sheet dated 8/3/23 documents R16 was admitted to the facility on [DATE]. R16's Cumulative Diagnosis Log documents diagnoses that include vitamin B and D deficiencies, atrial fibrillation, Alzheimer's disease, and congestive heart failure. R16's MDS (Minimum Data Set) dated 2/6/24 documents a BIMS (Brief Interview for Mental Status) score of 07, which indicates R16 has a moderate cognitive deficit. R16's Physician's Orders sheet dated 4/1/24 to 4/30/24 documents a diet order of Regular, Vegetarian. R16's Nutritional assessment dated [DATE] documents R16 is on a Regular, Vegetarian diet and documents R16's protein needs as 86 gm/day (grams/day). R16's undated current Care Plan documents a Problem/Need area of Potential risk for altered nutritional status and/or weight loss . This same Problem/Need area includes interventions of Provide diet as ordered Follow recommendations of RD/LDN (Registered Dietitian/Licensed Dietitian Nutritionist) . R16's laboratory (lab) results dated 8/16/23 documents a total protein of 5.6 with the normal range documented as 6.0 - 8.3 and an albumin level of 2.8 with normal range documented as 3.5-5.5. On 04/08/24 at 11:56 AM, an unknown staff member asked R16 what he wanted for lunch. R16 stated he wanted a burger with ketchup and onion. V21 (CNA/Certified Nursing Assistant) served R16 two boiled eggs, baked beans, and potato salad. When asked why he got eggs instead of the requested burger V21 stated R16 is a vegetarian. When this surveyor asked R16 why he got eggs instead of a burger, R16 stated he was a vegetarian. When asked why he asked for a burger if he was a vegetarian, R16 stated, Well, they have meatless burgers. R16 ate one egg and part of the rest of his meal. On 04/09/24 at 11:46 AM, R16 was served cooked broccoli, peanut butter and jelly sandwich, and a cupcake. R16 stated he didn't ask for peanut butter and jelly, they just gave it to him. On 04/09/24 at 12:07 PM, R16 asked staff to take him back to his room. When asked why he didn't eat the peanut butter sandwich, R16 stated he didn't want anything else. Week 2 menu's dated 10/23 provided to this surveyor by V7 (Dietary Manager) did not document a vegetarian menu. Week 2 Vegetarian menu dated 10/23 documents a blank line with a 0 next to it in place of the protein that is documented on the regular menu's. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 10:16 AM, when asked if she had any menus with R16's meal specific information on them, V7 (Dietary Manager) stated the menus she had provided this surveyor were all she had. V7 stated they have a list of items they have to serve R16 for protein. When asked how she ensured R16 was getting the recommended protein each day, V7 stated if the regular menu calls for four ounces of protein we try to give R16 four ounces of a protein substitute. V7 stated, Every so often I feel sorry for him and go buy him a veggie burger. This surveyor shared the observation of R16 asking for a burger and being served two boiled eggs, V7 stated sometimes we give him a veggie burger and he won't eat it. This surveyor shared the observation of R16 being served a peanut butter and jelly sandwich with cooked broccoli and not eating the sandwich. V7 stated R16 likes peanut butter. When asked how well peanut butter and broccoli went together, V7 stated she wouldn't want it. V7 stated R16 will usually tell them if he wants peanut butter or eggs. When asked how many ounces of protein was in an egg, V7 stated she didn't know without checking. When asked if it was documented somewhere for her to provide to this surveyor, V7 stated she didn't have it documented anywhere she would have to figure it up. When asked how much protein was in a peanut butter sandwich, V7 stated she wasn't sure and she didn't know what the dietary staff were doing. V7 stated R16's protein options were peanut butter, eggs, cottage cheese, and cheese. When asked if she had documentation of what protein V7 had been served the past month, V7 stated, Probably not. When asked if she didn't know the amount of protein in an egg or on a peanut butter sandwich how did she know R16 was getting the recommended daily amount of protein, V7 stated, I guess we don't. V7 stated the dietitian just told us to give him two boiled eggs so that is what we do. On 04/10/24 at 11:50 AM, V17 (Registered Dietitian) stated an egg has 5 or 6 grams of protein. when asked if two boiled eggs would be equivalent to a hamburger, V17 stated she couldn't answer that because it would depend on the product being used. V17 stated she hasn't been the dietitian at this facility long and isn't familiar with R16. V17 stated if the facility did not have a vegetarian spreadsheet she would check to see how much protein was served on a regular diet and then verify R16 was served the same amount of protein. When asked if he was assessed as needing 86 grams of protein a day would she expect that be what he was served, V7 stated that is estimated based on weight. V7 stated most menus provide for 90-100 grams of protein in their menu base. On 04/10/24 at 1:19 PM, when asked how much protein R16 was to have in a 24 hour period, V20 (Cook) stated,The way she explained it to me, he has to have what everyone else is getting. When asked who explained it to her and when they explained it to her, V20 stated, V7 (Dietary Manager) explained it today, (4/10/24). V7 (Dietary Manager) provided this surveyor with a handwritten menu for R16 for the week beginning 4/7/24. It documents R16 received the following protein options; Sunday, 4/7/24- breakfast- 2 eggs, lunch- cottage cheese, supper- grilled cheese; Monday, 4/8/24- breakfast- biscuits and gravy and egg, lunch -two eggs, supper- fish; Tuesday, 4/9/24- breakfast - two eggs, lunch- peanut butter and jelly sandwich, supper- grilled cheese; Wednesday- breakfast- hash brown, toast, and eggs, lunch- cottage cheese. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Vegetarian Diet policy dated 2022 documents, Indications for Use: the Vegetarian Diet is for individuals that desire to avoid animal products. This may be based on personal, religious or cultural beliefs. The Vegan or total Vegetarian diet if for those who desire to eliminate all animal products. The Ovo-Lacto Vegetarian Diet is a modification of the Vegetarian Diet that restricts all sources of animal protein except for dairy products .General Principles and Guidelines: 1. The Vegetarian Diet is planned using the menu components as outlined in Section 1 .2. An individual assessment and diet history is vital to assure that nutrient needs can be met with the Vegetarian Diet. 3. Depending on an individual's needs and food intake, it may be important to include mostly nutrient rich foods and only small amounts of low nutrient sweets and fats 10. Supplements should be considered based on individual needs: multivitamin or multivitamin with minerals, calcium, iron, vitamin D, and vitamin B12 in older adults and others as needed. The facility Cycle Menu policy dated 4/21 documents, It is the policy of (name of facility company) that a four-week cycle menu shall be used to 1. Ensure resident food preferences are considered. 2. Ensure nutritional needs of residents are met. 3. Eliminate need for constant menu planning. 4. Provide seasonal foods. 5. Control costs. Under Procedure the policy includes, .6. diets ordered which are not found on the modified spreadsheets shall be referenced using the Diet Manual and have posted instructions in the serving area.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation, and record review the facility failed to provide the diet as ordered for 1 (R25) of 5 residents reviewed for nutrition in a sample of 28. R25's Face sheet documents R25 is a male resident with a date of birth of 09/21/58 and an admitted [DATE]. R25's diagnosis in part: Hemiplegia following unspecified cerebvascular disease affecting right dominated, Essential hypertension, End stage renal disease, Hyperlipidemia, Type 2 diabetes with diabetic peripheral angiopathy, Unspecified sequelae of cerebral infarction, Unspecified systolic heart failure, Gastro-esophageal reflux disease without esophagitis, Peripheral vascular disease, Cerebral infarction, reduced mobility, Dysphagia, Muscle wasting and atrophy. R25's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 14 indicating R25 is cognitively intact. R25's Physician Order Sheet dated 04/01/24 documents dietary orders to include: double protein serving and no tomato products. On 04/08/24 at 12:10 PM, R25 received one hamburger patty on a bun with tomato, potato salad, baked beans, and cheesecake with his lunch. On 04/09/24 at 12:00 PM, R25 received 4 ounces of scalloped potatoes and ham, 4 ounces of broccoli, 1 roll with margarine and a half a frosted cupcake. On 04/08/24 at 11:10 AM, V7 (Dietary Manager) stated they are not following the menu today, they are having a cookout due to the eclipse. They are having hamburgers, hotdogs, baked beans, potato salad and cheesecake, which is one hamburger patty or one hotdog. R25's Dietary Quarterly assessment dated [DATE] documents a category labeled, Diet/Tube Feeding Order with diet unchanged documented, the same category dated 11/20/23 documents: regular diet, CCD (consistent carbohydrate diet), no straws, no bananas, OJ (orange juice), tomato products, or baked potatoes. R25's Dietary Notes dated 03/08/24 documents: late entry for 2/24 weight 124# (pounds), diet order : regular CCD diet, with 1500cc (cubic centimeters) fluid restriction (no bananas, OJ (orange juice), tomato products, or baked potatoes, limit milk to 0.5 cup daily. R25's weight is stable over past month. His intake is reported as 75% - 100% of attended meals per intake log. R25 receives dialysis three times weekly. The facility document titled, week 2 Tuesday documents for the CCD diet documents: 4 ounces of scalloped potatoes and ham, 4 ounces of broccoli, 1 each bread/margarine, and 1 each frosted cupcake. On 04/11/24 at 1:20 PM, V3 (Regional Consultant) stated, if the resident is ordered to have double protein they should be receiving them and if they are directed to not receive items by V17 (Registered Dietician) they should not be receiving them. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy dated 10/13 documents: Nutrition Supplements and Nourishments: It is the policy of (facility name) to provide additional calories and/or to residents who cannot and/or are not capable of consuming adequate nutrients through their regular meals. It is also the policy of (facility name) to provide guidelines for the selection, ordering, use and monitoring of nutrition supplements and nourishments.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to ensure the infection control program was followed using current standards of practice and per the facility policy for 7 of 8 (R6, R12, R13, R22, R24, R26, and R29) residents reviewed for infection control in the sample of 28. Findings Include: 1. On 04/08/24 at 12:50 PM, PPE (personal protective equipment) containers were noted sitting outside R2, R21, and R23's doors. There was no signage on these doors to indicate the type of transmission-based precautions these residents were on. V2 (DON/Director of Nurses) and V3 (Regional Consultant) stated there were no transmission-based precaution signs on those doors and they didn't know why the residents were on isolation precautions, or if they were. On 4/8/24 at 3:13 PM, V2 (DON/Director of Nursing) stated she wasn't sure why there were no signs posted on the door of R2, R21, and R23's rooms. V2 stated they are on enhanced precautions and the carts have been there since she started working at the facility in January, but she doesn't remember there ever being any signage on the doors. When asked if staff knew what PPE to wear in those rooms V2 stated she wasn't trained on Enhanced Precautions, and she doesn't know if staff were. On 4/8/24 at 3:30 PM, bins containing PPE were sitting outside R22, R24, and R26's rooms with enhanced precaution signs located on their doors. The containers were moved from in front of R2, R21, and R23's rooms. On 04/11/24 at 1:43 PM, V2 stated the PPE bins located in front of R2, R21, and R23's door were either in front of the wrong doors or those residents were no longer on precautions. V2 stated R2 used to have a catheter and the bin in front of R23's door should have been in front of R22's door and she wasn't sure why R21 had one in front of her door since R21 wasn't on precautions. On 04/08/24 at 3:18 PM, V18 (RN/Registered Nurse) stated the containers holding PPE have been in the hallway for a while. V18 stated there were signs on the doors but maybe they took them down when they painted. When asked when they painted, V18 stated she wasn't sure. When asked if staff knew what PPE to wear in those rooms without the signs, V18 stated, they should. On 04/08/24 at 03:35 PM, V10 (CNA/Certified Nursing Assistant) stated she remembered there being transmission-based precaution signs on some of the doors. V10 stated she would know what PPE to wear in each room without the signs, because they tell them in report. V10 stated they told her on 4/8/24 that she was to wear gloves in R24's room. This surveyor reviewed the Enhanced Barrier Precaution sign located on R24's door that documented to wear gown and gloves when providing care to R24, V10 stated she didn't remember them telling her to wear a gown. V10 stated she was trained on Enhanced Barrier Precautions. On 04/10/24 at 3:49 PM, V2 (DON) stated she would expect staff to wear gloves and probably a gown when providing care to residents on Enhanced Barrier Precautions. V2 stated she wasn't aware of Enhanced Barrier Precautions until yesterday 4/9/24. When asked if she trained staff after she became aware of it yesterday, V2 stated she had not but that she is going to. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R24's Profile Face Sheet dated 8/2/23 documents R24 was admitted to the facility on [DATE]. R24's undated Cumulative Diagnosis Log documents diagnoses that include bladder obstruction and acute kidney injury. R24's Physician's Order sheet dated 4/1/24 to 4/30/24 documents an order dated 4/8/24 of enhanced barrier precautions r/t (related to) foley catheter. 2. R12's undated New Admission Information sheet documents R12 was admitted to the facility on [DATE]. R12's MDS dated [DATE] documents R12 has a moderate cognitive impairment. This same MDS documents a Stage 4 pressure ulcer that was present on admission. R12's undated current Care Plan documents the following intervention under Patient Outcomes, 4/8/24 enhanced barrier precautions r/t (related to) wound. On 4/9/24 at 1:53 PM, this surveyor entered R12's room with V9 (LPN/Licensed Practical Nurse) and observed a sign on the door indicating R12 was on Enhanced Barrier Precautions. V12 (CNA) entered R12's room to assist V9. V9 and V12 were wearing gloves and neither V9 nor V12 donned any other PPE. V9 and V12 assisted R12 to reposition in bed and V9 (LPN) removed the dirty bandage from R12's coccyx. V9 removed the glove from her right hand and left the dirty glove on her left hand. V9 stated she didn't have two gloves to be able to replace both gloves. V9 did not perform hand hygiene on her right hand. V9 attempted to don a glove on her right hand without touching it with the dirty gloved, left hand. V9 was able to get the glove most of the way on her right hand by wiggling her fingers into place. V9 was not able to get the glove completely in place and pulled it the rest of the way onto her right hand using her left hand that still had the dirty glove on it. V9 cleaned the Stage 4 pressure ulcer located on R12's coccyx using her right hand. V9 applied the ordered treatment with a tongue depressor using her right hand. V9 attempted to take the sticky back off the dressing using her right hand only but was not able to get it completely off, so she used both hands to apply the dressing to the pressure ulcer. V9 removed both gloves, left the room, and washed her hands in the bathroom located across the hall from R12's room. This surveyor reviewed the Enhanced Precaution sign located on R12's door with V9. V9 stated R12 doesn't have any growth in her wound so it is probably in place just because R12 has a wound. V9 stated she never wears anything other than gloves when she administers the treatment to R12's pressure ulcer. On 04/10/24 at 3:49 PM, V2 (DON) stated hand hygiene should be performed after removing a dirty dressing. This surveyor reviewed the observation of V9 (LPN) attempting to change one glove to make a clean and dirty hand and asked V2 what her expectation would be in that situation. V2 stated V9 should have gotten more gloves. 3. R22's Profile Face Sheet dated 2/3/23 documents R22 was admitted to the facility on [DATE]. R22's MDS dated [DATE] documents a BIMS score of 07, which indicates a severe cognitive deficit. R22's current undated Care Plan documents a Problem/Need area of Alteration in Bladder Elimination with indwelling catheter . Interventions for this Problem/Need include 4/8/24 enhanced barrier precautions r/t (related to) cath (catheter). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/24 at 2:52 PM, this surveyor entered R22's room and observed a sign on the door that indicated R22 was on Enhanced Barrier Precautions. V15 (CNA) performed hand hygiene and donned gloves. V15 did not don any other PPE throughout the observation. V15 had a clean field set up on R22's bed side table that included a basin with soapy water, clean wash cloths, hand sanitizer, and a box of gloves. V15 took a washcloth and performed catheter care per current standards of practice. V15 then set the dirty washcloth down on her clean field next to a box of gloves and the stack of clean wash cloths. V15 then used a washcloth to dry R22's genital area. When asked if this was the PPE she normally wore when providing catheter care for R22, V15 stated it was. On 04/10/24 at 3:49 PM, V2 (DON) stated it was not standard practice to place dirty wash cloths on the clean barrier. 4. R26's undated New Admission Information sheet documents R26 was admitted to the facility on [DATE]. R26's undated diagnosis list documents R26's diagnoses include hip fracture, pacemaker, dysphagia, atherosclerosis. R26's MDS (Minimum Data Set) dated 11/29/2023 documents a BIMS (Brief Interview for Mental Status) score of 10, which indicates a moderate cognitive deficit. R26's undated current Care Plan documents handwritten at the bottom of the Care Plan, 4/8/24 enhanced barrier precautions r/t (related to) wound. On 04/10/24 at 2:32 PM, this surveyor entered R26's room and observed a sign on the door indicating R26 was on Enhanced Barrier Precautions. V9 (LPN) donned gloves and removed the dirty bandage located on R26's left heel. V9 cleaned the area and performed wound care per physician orders. V9 didn't removed her gloves and perform hand hygiene after removing the dirty bandage and before administering the treatment. When asked if she changed her gloves at any point during the observation V9 stated she hadn't. When asked if she should have V9 stated yes. This surveyor reviewed the Enhanced Barrier Precautions sign located on R26's door and V9 stated she wears gloves and no other PPE when providing care to R26. On 04/10/24 at 3:49 PM, V2 (DON) stated she would expect gloves to be changed after removing a dirty dressing and hand hygiene to be performed after each glove change. 48356 44492 5. R6's Profile Sheet documents R6 was admitted to the facility on [DATE] with a diagnosis of Urinary Tract Infection, Major Depressive Disorder, Morbid Obesity, Diabetes Mellitus (DM). R6's Minimum Data Set (MDS) dated [DATE] documents Section C, Brief Interview for Mental Status (BIMS) score is 11, moderately, impaired cognition, Section H, Bladder and Bowel documents indwelling catheter. R6's Care Plan dated 6/19/2023 documents Problem/Need: Alteration in Bladder Elimination with indwelling catheter. Diagnosis: Neurogenic bladder (16-20 french with 5-30cc bulb size, drainage to either bedside bag or leg bag per her choice; 4/8/2024 documents Goal: Will be free of symptoms of UTI (urinary tract infection) x 90 days with goal date of 6/12/2024, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's Physician's Order dated 6/18/2023 documents change foley catheter monthly and as needed (10 PM - 6 AM); 18 French (FR) with 30 cc bulb; foley catheter care every shift. On 4/9/24, 2:05 PM, V13, Certified Nurse Aide (CNA), assisted by V11 (CNA), were observed providing catheter care to R6. There was an enhanced precautions sign on the doorway neither staff member donned a gown. R6 was laying on her back in bed, covered with a blanket. V13 got a washcloth wet and applied no rinse peri wash to the rag. She washed down the center turned the washcloth and washed down one side, turned wash cloth again and washed down the other side, placed the dirty washcloth on her clean field next to the clean washcloths, got a clean wash cloth and wiped down the catheter tubing then washed up the tubing and repeated this process two more times. removed gloves did not do hand hygiene, put on new gloves and used a dry cloth to dry the area including the catheter tubing; gloves changed again with no hand hygiene performed. V13 stated she doesn't use hand sanitizer between glove changes. Stated she wouldn't be able to get gloves back on if she did. When asked why she placed the dirty washcloth in her clean field V13 stated she didn't remember. V11 and V13 both confirmed they only wear gloves when providing catheter care to R6. Surveyor: [NAME], [NAME] M. 6. R13's Admission and Discharge Record , undated documents an admitted [DATE] with Diagnoses of Chronic Obstructive Pulmonary disease (COPD), History of cellulitis, Psychosis, depression, Gastroesophageal reflux disease (GERD), Pulmonary Artery Disease (PAD), Chronic Kidney Disease stage 2, Major Depression, Peripheral Vascular Disease (PVD), Coronary Artery Disease (CAD), panic attacks, obesity, seasonal allergies, History of COVID, History of shortness of breath, history of shortness of breath, history of tracheostomy, History of gastroesophageal tube, Insomnia, left leg venous ulcer, sleep apnea, inability to care for self. R13's Minimum Data Set(MDS) dated [DATE] documents in Section C a brief interview of mental status score of 14 which indicates that R13 is cognitively intact. R13's Care Plan undated current care plan with goal dated of 04/30/24 documents under problem: Wound on left lower leg: Shearing wound of left anterior lower leg, Arterial wound of left anterior lateral ankle, shearing wound of left upper lateral leg. Resident is at risk of unavoidable poor wound healing and unavoidable complications related to peripheral vascular disease (PVD), Peripheral Artery Disease (PAD), and her history of declining wound consultant services or wound care. Goal- wound will demonstrate progressive healing and will be free of acute infection by next review date. Interventions include in part- Keep legs clean and dry when treatment is refused. Notify doctor of refusals. Problem- at risk for skin breakdown related to PVD and PAD. Goal- will have no new open areas caused by pressure or friction. Interventions include in part- 01/03/24 Change wound care and start Bactrim for Methicillin Resistant Staphylococcus Aureus (MRSA) in Left lower Extremity (LLE) wound contact isolation, 04/08/24 enhanced barrier related(r/t) wound when not already on contact isolation. R13's Physician orders for 04/01/24 to 04/30/24 document under treatment orders gentamicin ointment 0.1% apply topically once daily to left lower extremity after normal saline cleanse apply calcium alginate and rolled gauze ordered date of 01/04/24 and Contact isolation Methicillin-Resistant staphylococcus wound ordered date of 04/08/24. On 04/08/24 at 9:05AM, contact precaution sign noted on R13's door. No Personal Protective Equipment noted outside of R13's door. No isolation disposal bins observed in R13's room. (continued on next page)

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	146121	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benton Rehab & Hcc	1409 North Main Street Benton, IL 62812

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/09/2024 at 8:52AM, a cart with personal protective equipment (PPE) was noted on the outside of R13's room with personal protective equipment in it. Contact isolation sign on door. Observed two red bins in R13's room. On 04/09/24 at 9:00AM, R13 stated that she did have red infection control bins in her room, she had them hid behind her wheelchair to give her room. R13 said that she also had the PPE bin in her room as well to give her more space. R13 said she put it behind her wheelchair in the corner of her room. R13 said that staff came in last night and told her that she needs to have disposal bins out in the room so that staff can see them. R13 said that staff also moved the the PPE bin outside of the door. R13 said that the staff told her that it needs to be on the outside of the room. R13 said that when they come in to change her dressings that they usually throw the old dressing in the red bin in her room. On 04/10/24 at 10:08AM, V9 (Licensed Practical Nurse/LPN) was noted walking into R13's room that has a contact precaution sign on door without putting on any Personal protective Equipment. V9 had supplies to do R13 treatment in her hands. V9 put on a pair of gloves and removed old dressing that was dated 04/09/24. V9 with her dirty gloves touched the privacy curtain to move it back out of the way, she then touched the light switch to turn on the lights with her dirty gloves on. V9 had a trash bag on R13's bed that she disposed of the old dressing in. V9 removed her dirty gloves and put them in the trash bag on the bed. V9 did not wash her hands or place hand sanitizer on her hands before putting new gloves on. Treatment was performed as ordered. V9 then took off her gloves and did not wash her hands nor sanitized them. V9 grabbed the trash bag with the soiled dressing and tied it up with her bare hands. V9 then took the soiled bag out of the room and entered the medication room with the bag. On 04/10/24 at 03:49 PM, V2 (DON) stated that in a contact isolation room she would expect the staff to don a gown and gloves. V2 stated she would expect V9 to change gloves and perform hand hygiene after doing the dressing. V2 stated that V9 should not of taken the bag with the soiled dressing in it out of the room. she said that was wrong, V2 said that V9 should have put the dirty dressing in the disposal bin in the resident room. On 04/11/24 at 12:55PM, V9 stated that she should of had a glove, gown and mask on before entering R13's room cause she was on contact isolation. V9 stated that she should of never took out the bag that contained the soiled dressing and place it in the trash can in the medication room. V9 said that she should of disposed of the soiled dressing and trash bag in the red bin in R13's room. 7. R29's New admission Information sheet, undated documents an admitted [DATE] with diagnosis of Cerebral Vascular accident (CVA), Acute right middle cerebral artery cerebral infarction, Left Hemiparesis, Hypertension, Left bundle branch, Hyperlipidemia, diabetes mellitus type 2, seizure disorder, chronic obstructive pulmonary disease(COPD), history of tobacco use, Chronic post traumatic headache, wasting syndrome, drug dependence, depression, anxiety, Post Traumatic Stress syndrome, occlusion of both carotid arteries. R29's Minimum Data Set(MDS) dated [DATE] documents in Section C a Brief interview for mental status score of 11. Which indicated that R29 has some cognitive impairment. Section GG documents eating as not attempted due to medical condition, toileting and positioning as dependent. Bathing, upper and lower body dressing as substantial/maximal assistance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R29's Care Plan dated 03/08/24 documents problem of Peg tube with jevity with a goal of maintain weight and tolerates tube feeding. Interventions include in part. Enhanced barriers precautions dated 04/08/24, give Jevity per orders, consult with dietician, flush as ordered, clean site and dressing per orders. Problem urinary Catheter goal of catheter intact and urinary tract infection (UTI) free. Interventions include perform catheter care every shift, catheter change monthly and as needed (PRN), notify doctor of sediment or blood, monitor for pain and monitor output. R29's Physician orders for 04/01/24 to 04/30/24 document Jevity 1.5 give 1 can 5 times daily, flush with 50ml water before and after each bolus ordered 03/12/24, Flush tube with 80ml water two times a day ordered on 03/12/24, Enhanced Barrier Precautions ordered on 04/08/24. On 04/08/2024 at 9:10AM, there was a sign located on the door of R29's room that documents Enhanced Barrier precautions. There was a 3 drawer bin on the outside of R29's door with Personal Protective Equipment in it. On 04/09/2024 at 2:00PM, V11(Certified Nurse Assistant (CNA) and V12 (CNA) were noted in R29's room performing catheter care and peri care to R29. V11 and V12 did not don Personal Protective Equipment prior to performing Catheter care and peri care. V11 and V12 only had gloves on when performing care. Catheter care and peri care were performed per professional standard of practice. On 04/09/2024 at 2:15PM, V9 (Licensed Practical Nurse) was noted in R29's room where V9 performed a pressure ulcer treatment to R29's coccyx. V9 performed treatment per current orders and per professional standards of practice. V9 did not have any personal protective equipment on when performing treatment other then gloves. On 04/10/24 at 10:31AM, V9 went into R29's room to give feeding. V9 did not place any personal Protective Equipment on prior to entering R29's room. R29's room has sign that states Enhanced Barrier Precautions on door. V9 placed gloves on and administered 50ml of water via gastroesophageal tube(G-Tube) then V9 administered the feeding. No personal protective equipment other then gloves was used during feeding. On 4/10/24 at 03:49 PM, V2 (DON) stated that staff should probably be wearing Personal Protective Equipment while administering a feeding via G-tube, but she wasn't sure. The facility Hand Hygiene policy dated 12/7/18 documents, Policy: All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contact and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them is an important component of the infection control and isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Enhanced Barrier Precautions policy dated 7/13/23 documents, Purpose: to reduce transmission of multidrug-resistant organisms (MDRO). Enhanced Barrier Precautions (EBP) should be used when contact precautions do not apply, for residents with any of the following: Open wounds that require a dressing change, Indwelling Medical Devices, Infection or colonized with a MDRO Enhanced Barrier Precautions require use of a gown and gloves during high-contact resident care activities that provide opportunities for the transfer of MDRO's to staff hands and clothing. EBP is primarily intended to use for care that occurs within a resident's room, EBP should be followed when performing transfers in the shower/assisting with shower and when assisting a resident with toileting in common restrooms. High-contact care activities include dressing, bathing/showering, transfers (when bundled with other high-contact resident care activities, hygiene, changing linens, changing briefs or toileting, caring for medical devices .wound care, skilled therapies Procedures: 1. Educate staff on EBP. 2. Identify resident with an infection or colonized with a MDRO, residents with medical devices or chronic wounds that do not require contact precautions. 3. Review Contact precautions to ensure that Enhanced Barrier Precautions are appropriate. 3. Post approved EBP signage that indicates high-contact activities. 4. Ensure that disposable or washable isolation gowns and gloves are available to HCP (Health Care Personnel), where high-contact resident care activities may be required. 5. Keep a container or hamper inside resident's room for HCP to dispose of PPE. 6. Track residents to determine potential removal of EBP The Facility policy Transmission Based Precautions, dated 10/2023 states under Policy, Transmission Based Precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission. Notes document in part Contact Precautions: are designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Direct contact transmission involves skin to skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when personnel turn resident, bathe residents, or also can occur between two residents (e.g:by hand contact), with one serving as the source of infectious microorganisms and the other as a susceptible host. Indirect contact transmission involves contact of susceptible host with a contaminated intermediate object usually inanimate in the resident's environment. Contact precautions apply to specified residents known or suspected to be infected or colonized(presence of microorganism in or on a residents, but without clinical signs and symptoms of infection) with epidemiologically important microorganisms that can be transmitted by direct or indirect contact. Staff procedures for contact precautions include: Use of Personal Protective Equipment (PPE) including gloves and gowns for all interactions that may involve contact with the patient or the patients environment. Donning PPE upon room and entry and properly discarding before exiting the patient room is done to contain pathogens, use disposable or dedicated patient care equipment when accessible for things such as blood pressure cuffs, thermometers, etc, limit transportation or movement of the patient outside of the room to medically-necessary purpose, and patient should be in a single patient room if available, if unavailable then decision should be made balancing risks to the other patient.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 41610 Based on observation, interview, and record review the facility failed to provide at least 80 square feet of living space for 5 of 5 residents (R1, R16, R22, R26, R27) reviewed for room size in a sample of 28. Findings include: On 4/10/24 at approximately 2:30 PM, R27 was sitting in her room. R27 was noted to have a roommate but the roommate was not in the room at the time. The room was a smaller sized bedroom with two beds, 2 night stands and an inset dresser inside the room. On 4/10/24 at 2:33 PM, R26's room was noted to be a smaller sized bedroom with two beds and two night stands and an inset dresser. On 04/10/24 at 10:10 AM, R26 who was alert to person, place and time stated she does not have concerns with her room size. On 4/10/24 at 2:35 PM, R1 was sitting in R1's room. R1 was noted to have a roommate but the roommate was not in the room at the time. It was a smaller sized bedroom with two beds, two night stands, one inset dresser, and one high back wheelchair. The room had limited area to move around inside. On 4/10/24 at 2:37 PM, R16 and R22 were in a room together. It was smaller sized bedroom with two beds and two night stands and one inset dresser. This room had limited area to move around inside. On 04/10/24 between 2:30 PM and 2:37 PM, V3 (regional consultant) measured R1, R16, R22, R26, R27's bedroom sizes. The rooms measured 12 feet 8 inches by 11 feet 11.5 inches, indicating that the rooms were 151.47 square (sq.) feet (ft.), or 75.74 sq. ft. per bed. The measurements did not include the closet or the inset dresser area. On 4/8/24 at 10:30 AM, V1 (Administrator) stated that both halls of the facility (where R1, R16, R22, R26, R27 reside) have a room size waiver. V1 stated currently most residents do not have a roommate but all rooms are still certified for two residents. V1 stated rooms 1 - 18, 20 - 25, and 30 - 33 are all waivered rooms and don't meet the proper room size. V1 stated they were all Medicare and Medicaid certified. A facility room roster provided by the facility on 4/8/24 and dated 4/4/24, documents that R1, R16, R22, R26, R27 reside in the rooms observed and measured by V3. Inquiries regarding the size of these rooms during the survey from 04/08/24 to 04/11/24, found no concerns or negative interviews from residents or families of residents who reside in the waivered rooms. During an interview, on 04/10/24 at 10:10 AM, R16, R22, R26, and R27 voiced no concerns with the size of their rooms. Review of 6 months of Resident Council meeting minutes indicated no concerns related to the size of the rooms.