STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146139	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care	2120 West Washington Springfield, IL 62702

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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 - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interview and record review, the facility failed to answer resident's call lights to address their needs and promote resident dignity for 6 of 6 residents (R9, R16, R25, R30, R33 and R285) reviewed for dignity in the sample of 42. This failure resulted in R285 becoming incontinent and feeling humiliated. Findings include: 1. R285 was admitted on [DATE] with diagnosis of, in part, fracture of left fibula, left tibial fracture, fracture around internal prosthetic left knee joint, and retention of urine. R285's Care Plan dated has an ADL Self Care Performance Deficit requires substantial/maximal assistance from staff participation for toileting hygiene and transfers and requires substantial/maximal staff participation with personal hygiene and set up help from staff with oral care. On 3/10/25 at 12:50 PM, R285 stated she will wait a minimum of 30 minutes or more to have her call light answered. R285 stated, I've had to wait so long and accidentally soiled myself because I couldn't wait any longer. It's humiliating. The facility policy Call Light dated 8/1/05 documents it is the policy of this facility to maintain the highest quality of care for its residents. The policy documents to answer call light promptly. The policy documents if you are unable to meet resident request or need, leave call light on and obtain assistance from charge nurse. 32874 2. During the resident council meeting held on 3/12/2025 at 2:30PM, R9, R16, R25, R30, and R33 all stated call lights are not answered timely. All stated could take up to 30 minutes to get light answered. R9's Minimum Data Set (MDS) dated [DATE] documents R9 is cognitively intact. R16's MDS dated [DATE] documents R16 is cognitively intact. R25's MDS dated [DATE] documents R25 is cognitively intact. (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 - Actual harm Residents Affected - Few	R30's MDS dated [DATE] documents R30 is cognitively intact. R33's MDS dated [DATE] documents R33 has moderate cognitive impairment. The facility resident council minutes dated 2/27/2025 documents under old business any unresolved issues since last month residents state Certified Nursing Assistants (CNAS) still take awhile to answer call lights. Resident council minutes dated 1/31/2025 documents old business any unresolved issues last month CNAs are still taking a long time to answer call lights, new business residents state the CNAs come to find out the reason the light is on and leaves without fixing the issues, residents stated CNAs are very late answering call lights at night.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to develop and implement a baseline care plan for 1 of 16 residents (R185) reviewed for baseline Care Plan in the sample of 42. Findings include: R185's Face Sheet, print date of 3/12/25, documents R185 was admitted on [DATE] with a diagnosis of History of Falling. R185's Clinical Admission, dated 3/6/2025, documents, Mental Status: Resident is confused. Oriented to person. Confused: Chronic. Level of cognitive impairment: Moderate impairment (memory loss). Resident is coherent. Speech is clear. Language barrier: No Genitourinary: Ostomy (including urostomy, ileostomy, and colostomy). Urinary catheter intact. Urine amber in color. Urine retention noted. Genitourinary Note: Hospital stated resident has urinary retention. On 3/11/25 R185's Electronic Medical Record fails to document a Care Plan for R185 addressing her medical and safety needs. On 3/11/25 at 11:00 AM, V1, Administrator, stated Normally when a person is admitted , and the nurse does the Admission Assessment the computer program generates the interim Care Plan. The nurse that did (R185's) Admission Assessment did not answer the Care Plan questions so an interim Care Plan was not created. The policy Care Plan Process, dated 11/2017, documents, The Baseline Care Plan will be completed and implemented within 48 hours of admission. This Care Plan will include instructions needed to provide person centered care that meets professional standards of quality. At a minimum, the baseline care plan will address the resident's initial goals for stay, dietary, therapy and social services needs, as well as PASSAR (Preadmission Screening and Resident Review) recommendations if applicable. Necessary physician orders will be included as well.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on observation, interview and record review, the facility failed to have an updated resident centered Care Plan to address the current needs of the residents for 2 of 16 resident (R21, R42) reviewed for Care Plan in the sample of 42. Findings include: R21's Face Sheet, print date of 3/12/25, documents R21 was admitted on [DATE] and has a diagnosis of Dependence on Renal Dialysis. R21's Pre/ Post Dialysis Evaluation, dated 3/4/25, documents, Access site: Access site location: LUE (Left Upper Arm). R21's Care Plan, dated 9/8/23, documents, (R21) has renal failure r/t (related to) End Stage disease. Receiving hemodialysis with (Dialysis Center) on Tuesday (Tuesday), Thur (Thursday), Sat (Saturday) mornings. Interventions: Assist resident with ADL's (Activities of Daily Living) and ambulation as needed. Fluid Restriction as ordered. (1500ml (milliliters) as ordered. Give good oral hygiene. Give medications as ordered by physician. Monitor changes in mental status; Lethargy, Somnolence, Fatigue, tremors, seizures. Monitor for s/sx (signs and symptoms) of hypovolemia or hypervolemia. Monitor vital signs as ordered. Plan rest periods as needed. weight monitoring 3 x weekly. To be done at dialysis. This Care Plan fails to document R21's Let Upper Arm fistula, do not use left arm for blood pressure or blood draws. On 3/12/25 at 3:35 PM, V1, Administrator, stated R21's Dialysis Care Plan is not complete related to it does not document the fistula site and do not use left arm for blood pressures or blood draws. 2. R42's Face Sheet, print date of 3/12/25, documents R42 was admitted on [DATE] and has Hemiplegia and Hemiparesis following a stroke and Epilepsy. R42's Bed Rail Evaluation, dated 11/22/24, documents R42 has bilateral 1/2 bed rails. On 3/11/25 at 10:04 AM, R42 is in bed with 1/2 bed rails raised. V25 Certified Nurse Aide stated that R42 does try to use them when he is being turned. R42's Care Plan, dated 12/7/23, documents, (R42) is at risk for limited physical mobility r/t hemiparesis / hemiplegia. Intervention: Side Rails: 1/4 side rails, x 2 bilaterally, to promote bed maneuverability due to hemiparesis / hemiplegia. The policy Resident Assessment and Care Planning, dated 11/2017, documents, The facility must evaluate and modify, if necessary, the efficacy and appropriateness of each resident's care plan on at least a quarterly basis, and with a significant change in condition.

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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** 44967 Based on observation, interview, and record review, the Facility failed to ensure showers, and basic grooming assistance was provided for 1 of 24 residents (R2) reviewed Activities of Daily Living (ADLs) in the sample of 42. Findings include: R2's Admission Record, undated, documents R2 was admitted to the facility on [DATE] with diagnosis of Congestive Heart Failure, Chronic Kidney Disease, and Osteoarthritis. R2's Care Plan, dated 2/3/25, documents R2 scored an 11 on her BIMS (Basic Interview for Mental Status - 13-15= Intact cognitive response, 8-12= Moderate Cognitive Impairment, and 0-7= Severe Cognitive Impairment). R2 understands need for placement and can express her needs. Interventions: needs assistance with all decision making. R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a moderate cognitive impairment and requires partial/moderate assistance from staff for bathing and dressing. On 3/10/25 at 10:05 AM, R2 was seen sitting on the side of her bed and appears to have greasy hair. R2 stated she has not had a shower or a bath in a long time. On 3/11/25 at 8:45 AM, R2 stated she did not get a shower last evening and is unsure when she last had a shower or bed bath. R2's hair still appears very greasy, combed, and matted. On 3/12/25 at 8:55 AM, R2 sitting in wheelchair next to her bed. R2's hair appears very greasy and combed back with flakes in her greasy hair. R2 stated the only time they wash me up is when they are cleaning me down there (pointed to groin area). R2 stated My hair needs washed, it really feels dirty, and I would feel a lot better after getting a shower. I'm not sure I can stand up to get a shower, I will probably drown. On 3/12/25 at 8:58 AM, When asked about R2 getting showers, V13, Certified Nursing Assistant (CNA), stated (R2) gets a shower on Monday and Thursday Evenings, so I would not have anything to do with it. On 3/12/25 at 9:05 AM, V12, Licensed Practical Nurse (LPN)/Wound Nurse, stated I collect the resident shower sheets from the staff and do weekly audits with them. When told that R2 has greasy hair and stated she has not had a shower in a long time, V12 stated There are no shower sheets in my binder for the month of February or March for (R2). When asked about her audits she completed, V12 stated Well, I don't want to tell you this, but it looks like (R2) has not had a shower since she's been here. I believe I even asked the CNAs for (R2's) shower sheets and they had none to give me. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 9:15 AM, V12, stated I called every CNA who was working with (R2) on the shower days and asked them why (R2) didn't get a shower and they all said they filled out a shower sheet and/or (R2) refused a shower. I had each one of them come in last night to fill out a shower sheet from that day they worked. V12 provided handwritten notes indicating R2 refused, and some shower sheets that were completed last evening (3/12/25). On 3/13/25 at 10:25 AM, V1, Administrator, stated I would expect the staff to ensure all residents are getting their showers as scheduled. I agree, if the shower sheets weren't done and (R2) has greasy hair, the showers probably weren't done. On 3/13/25 at 12:00 PM, V1, stated We have looked and cannot find any policy for showers or ADL Care of Residents.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on observations, and record reviews the facility failed to clarify pre-operative instructions and document and notify the physician a change in condition while providing medical treatment without an order for 1 of 2 residents, (R45) reviewed for quality of care in the sample of 42. Findings include: R45's Face Sheet, undated, documented R45 was admitted to the facility on [DATE] with diagnosis of, in part, atrial fibrillation, abnormalities of gait and mobility, hypertension, and malignant neoplasm of colon. R45's Minimum Data Set (MDS) dated [DATE], documented she is cognitively intact and does not use oxygen therapy of any form. R45's Care Plan dated 2/6/25, does not include any care plan regarding R45 requiring the use of oxygen or respiratory issues. On 3/10/25 at 10:52 AM, R45 had an oxygen concentrator set up next to her bed with oxygen turned on to 3 Liters nasal cannula being administered to her as she was lying in bed. The oxygen concentrator had humidification attached and dated 2/27/25. R45 stated she was having back pain, and she gets pain medication for it. As R45 was speaking, she paused several times and closed her eyes as if she was falling asleep but did not have any complaint of shortness of breath. On 3/10/25 at 12:42 PM, R45 had blue tinged lips, not wearing oxygen, sitting in her chair eating lunch at bedside table. R45 was speaking normal at this time and stated she was feeling fine. R45's Progress notes dated 3/11/2025 at 12:21 AM, documented, Resident o2sat (oxygen saturation) at 60% o2 started immediately 2l (liters) resident sent to ER (emergency room) for eval (evaluation) and TX (treatment)- MD (medical director) - POA (power of attorney) and nurse manager notified. R45's Progress notes dated 3/11/2025 at 6:15 AM, documented, Hospital - Admitting DX (diagnosis) - Acute Hypoxia. R45's Progress Notes, dated 3/11/25 at 10:06 PM, documented, writer entered residents room to pass medications and observed resident asleep in bed. writer woke resident up asked her how she felt and responded with just a little tired. resident stated she wanted to get up out of bed and dressed. writer checked to verify shower chart and confirmed it was residents shower day. writer asked if she wanted to get in shower and she replied with yes. writer did not at that time notice anything out of the ordinary other than her still being in bed. after resident was out of shower and up in w/c writer entered room to check on resident then and did notice residents lips a light blue color. writer took vitals and found O2 to be a little low at 88. resident has standing orders to apply oxygen as needed. writer placed oxygen on resident monitored residents pulse-ox encouraging resident to take big breaths in nose and out mouth, residents oxygen did come back up to and floated from 92-93. resident did say this helped her feel better. writer made sure call light was in reach and to call if she needed anything. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 9:18 AM, V1, Administrator, stated she didn't see any assessment or transfer documentation in R45's electronic medical record (EMR) chart from her being sent out to the hospital for hypoxia. V1 stated she did not see any orders for R45 to be on oxygen and no charting to say why she was even started on it. On 3/11/25 at 9:30 AM R45's oxygen concentrator is at the side of her bed with humidification bottle dated 3/1/25 now. There is a sign posted outside R45's door stating, no smoking, oxygen in use, no open flames and enhanced barrier precautions. On 3/11/25 at 10:01 AM, V8, Medical Director, MD, stated the facility did not call me or my office to tell me R45 was sent to the hospital last night. V8 stated she does not have any orders for R45 to be on oxygen from any of her notes but will look into details on what was going on. At 10:24 AM, V8 stated the hospital admitted R45 for hypoxia and ruled out multiple diagnosis to be the cause but still did not know what is causing it. V8 stated the facility has standing orders to be able to administer oxygen if a resident is short of breath but they are supposed to notify me if this is needed. V8 stated she was never notified that R45 had been using oxygen, that would be a change from her normal condition. V8 stated R45 did not require oxygen and did not know the facility had been administering it to her. V8 stated the facility should have notified me of any change in condition for R45, which was not done. On 3/11/25 at 9:31 AM, V5, Licensed Practical Nurse, LPN, stated she has taken care of R45 many times. V5 stated R45 wears oxygen at night at 2L nasal cannula and has been on it for a long time now, it's not something new. V5 stated she could not find an order for oxygen in R45's chart. On 3/12/25 at 8:40 AM, V1, Administrator, stated V8 said her office received a faxed notification of R45's condition from the night she went out but did not find it until today. V1 stated she expects her nurses to be notifying the provider via phone not by fax and she will have to do some education on that. On 3/12/25 at 3:15 PM, V1 stated she expects the medical provider to be notified of any change in condition including is a resident is placed on oxygen. The facility's Guidelines for Physician Notification of Change in Resident Condition with revision date of 4/2019, documented the standard is for staff to observe, document and communicate to the physician changes in resident condition promptly. The policy continued to document a change in condition may include abnormal or deviation from normal vital signs. The facility's policy included under notification of changes that a facility must immediately inform the resident; consult with the resident's physician when there is a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The policy also documented that it is the responsibility of each nurse to notify the physician of a significant change in condition before the end of the shift.

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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. 32874 Based on observation, interview, and record review the facility failed to provide dressing to pressure sore for 1 of 5 residents (R40) reviewed for pressure sores in the sample of 42. Findings include: On 3/12/2025 at 8:40AM V14, Certified Nursing Assistant (CNA) removed R40's adult diaper. R40 did not have a dressing to pressure ulcer on coccyx. R40 was incontinent of stool. V14 CNA stated, they normally put a bandage on her sore. V14 placed another adult diaper on R40 and placed her in a wheelchair without a dressing on R40's pressure ulcer. R40's physician orders (PO) dated 1/22/2025 documents control gel formula dressing; apply to coccyx topically, Monday, Wednesday, and Friday day shift for stage 2 pressure injury. On 3/13/2025 at 9:51 AM, V12, Wound Nurse, stated dressings are to be in place as ordered for pressure sores. V12 stated I did her treatment right before I left yesterday, I would have forgot but the staff reminded me. The facility policy entitled Wound and Ulcer policy and Procedure dated, revised dated 3/28/2024 documents it is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management. The policy documents initiate the treatment protocol appropriate for the stage of the ulcer or the wound assessed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed, supervise a meal, to store an oxygen cylinder and transfer residents with a full mechanical lift in a safe manner for 3 of 5 residents (R1, R42, R51) reviewed for accidents in the sample of 42. Findings include: 1. R42's Face Sheet, print date of 3/12/25, documents R42 was admitted on [DATE] and has Hemiplegia and Hemiparesis following a stroke and Epilepsy. R42's Minimum Data Set (MDS), dated [DATE], documents that R42 is moderately cognitively impaired and is dependent on staff for transfers. R42's Event Note, dated 1/30/2025 at 5:15 PM, documents, Situation: writer was called into room by CNA (Certified Nurse Aide). Writer was told that while transferring resident with mechanical lift, one CNA maneuvering lift and one CNA with hands on resident directing into wheelchair, when sling shifted, and bottom right hook strap became unhooked, and resident fell on to buttocks and then fell back and hit his head on the floor. CNAs were unable to catch resident or assist fall with it happening so fast. Background: resident was being transferred via (full) mechanical lift Assessment (RN) (Registered Nurse)/Appearance (LPN) (Licensed Practical Nurse): VSS (vital signs stable) ROM WNL (range of motion within normal limits) for resident. Recommendations: (no documentation entered) R42's Fall Management Review, dated 1/31/2025 11:43, documents, Situation: Resident fell on to buttock during a full mechanical lift transfer Background: Resident was being transferred using a full mechanical lift with the assist of 2 CNAs. During transfer, the strap became unhooked from the lift causing the resident to fall to the floor on his buttock. The CNAs were in correct position, one maneuvering the machine and the other with hands on the resident guiding him to the w/c (wheelchair). Assessment (RN)/Appearance (LPN): Resident was lying on back/buttock on the floor. Did his head on the floor. No visible injuries. ROM WNL. On 3/11/25 at 9:40 AM V11 Certified Nurse's Aide (CNA) and V25 CNA entered R42's room to transfer R42 from the wheelchair to a shower chair using a full mechanical lift. V11 and V25 both attached the sling loops to the hoist. Neither pulled down on the sling loops. V25 began to raise the lift, V11 was holding the sling neither double checked the sling loops. R42 was transferred to the shower chair. On 3/11/25 at 9:58 AM, V11 and V25 transferred R42 from the shower chair to the bed. V11 and V25 both attached the sling loops to the hoist. Neither pulled down on the sling loops. V25 began to raise the lift, V11 was holding the sling neither double checked the sling loops. R42 was transferred to the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 2:15 PM, V1, Administrator, stated the way I understand it the CNAs did not check the sling straps and the strap slid off of the hoist. The aides should be double checking the straps and aide should always have hands on the sling and steady the sling while using the full mechanical lift. The manual Hoyer' Presence, undated, fails to document checking the sling and keeping the sling steady. 2. On 3/10/25 at 12:20 PM, R1 is sitting in his room eating his lunch unsupervised. On 3/11/25 at 8:35 AM, R1 is in the dining room eating breakfast. On 3/11/25 at 9:20 AM, R1 stated, A few days ago I started coughing while I was eating. They sent me to the hospital and since I have been back sometimes, they let me stay in my room and sometimes they make me go out to dining room. Yesterday they let me stay in my room for 2 meals but this morning they made me go out to the dining room. R1's Physician Order, dated 2/24/25, documents, SUPERVISION AT ALL MEALS. MUST BE IN DINING ROOM AT MEALTIMES. R1's Physician Order, dated 3/11/25, documents, 'Oxygen 3 lpm (liters per minute/ nasal cannula or face mask q (every) shift as needed for dyspnea. R1's Nurses Note, dated 2/22/25, documents, At approximately 1315 writer had been called into resident's room by roommate's sister. She reported that resident was choking on his meal. Writer was able to make sure resident was able to breathe and resident stated he could. Writer looked into resident's mouth and found no food particles. Resident kept coughing and coughing up large pieces of food. Lungs sounds diminished but with some rubbing noises could be heard. Resident stated he could feel fullness in his chest. He kept coughing up multiple food particles. Resident also had emesis several times. Resident able to talk but talking causes him to cough again and in which food particles come up with each cough. Resident remains on 4L (liters) O2 (oxygen) via NC (nasal cannula). Writer has call out to V27 Physician (which he is on call this weekend). Awaiting call back at this time. Writer has call out to POA (Power of Attorney). On 3/13/25 at 7:50 AM, V1, Administrator, stated R1 did not choke he was just having a swallowing issue. I will have to look into if he can eat in his room by himself. On 3/13/25 at 9:40 AM, V2, Director of Nurses, stated after R1's coughing incident R1 was seen by Speech Therapy, and they are the ones that recommended R1 not to eat unsupervised which he should not be doing. On 3/11/25 at 9:20 AM, R1 is sitting in his room. There is a single oxygen cylinder sitting on the floor. The oxygen cylinder is not in an oxygen stand or cart to prevent tipping or falling. On 3/12/25 at 1:40 PM, V1, Administrator, stated, I had that hall checked for oxygen tanks Monday. I guess they didn't see it. (continued on next page)

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Regency Care	2120 West Washington Springfield, IL 62702

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 8:15 AM R1 is in his bed with bilateral side rails raised eating breakfast. There is a single oxygen cylinder sitting on the floor. The oxygen cylinder is not in an oxygen stand or cart to prevent tipping or falling. R1's Face Sheet, print date of 3/12/25, documents R42 was admitted on [DATE] and has diagnoses of Pneumonia and Congestive Heart Failure. R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact. The policy for Walk About Oxygen Cylinders, dated 8/2009, documents, All cylinders must be kept secure: 1. Tanks must be in a cart, rack or chained to a wall. 44967 3. On 3/11/25 at 11:35 AM, V9, CNA, and V7, CNA, brought in the full body mechanical lift device to get R51 out of bed and to her wheelchair. V9 controlled the lift device while V9 got R51's wheelchair ready. R51 was lifted off her bed and turned around while hanging freely in the air and no one holding onto her. R51's wheelchair was approximately 6 feet away from her bed and R51 was pulled over to her wheelchair while swinging freely in the air. Several attempts made to lower R51 to the wheelchair with R51's sling sideways, both CNAs turned R51's wheelchair sideways and R51 then lowered to wheelchair. On 3/11/25 at 1145 AM, V9 stated to V7 I know we are supposed to keep a hold of the resident at all times when the state is watching us. I just noticed that we did not do that. R51's Care Plan, dated 2/20/25, documents R51 is at risk for falls. Interventions: 2/19/25 may use (full body mechanical lift device) lift for transfers as needed. PT to eval for knee brace. It continues R51 Safety with interventions: Safety measures - including strategies to reduce the risk of infection, falls, injury initiated as appropriate. R51's MDS, dated [DATE], documents R51 is cognitively intact and requires substantial/maximal assistance from staff for transfers. On 3/13/25 at 10:25 AM, V1, Administrator, stated I would expect the staff to hold onto the resident at all times during a (full body mechanical lift) transfer.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to provide complete incontinent care to prevent urinary tract infection for 5 of 5 residents (R20, R40, R51, R60, R185) reviewed for urinary incontinence in the sample of 42. Findings include: 1. R185's Face Sheet, print date of 3/12/25, documents R185 was admitted on [DATE] with a diagnosis of History of Falling. R185's Clinical Admission, dated 3/6/2025, documents, Mental Status: Resident is confused. Oriented to person. Confused: Chronic. Genitourinary: Ostomy (including urostomy, ileostomy, and colostomy). Urinary catheter intact. Urine amber in color. Urine retention noted. Genitourinary Note: Hospital stated resident has urinary retention. R185's Health Status Note, dated 3/9/2025 06:40, documents, Note Text: ER (emergency room) nurse called with report. Resident is being sent back on ABT (antibiotic) for UTI (Urinary Tract Infection). On 3/10/25 at 12:09 PM, V11, Certified Nurse Aide (CNA), entered R185's room to provide care. R185 is lying in a low bed. R85 has an indwelling urinary catheter. R185's urinary drainage bag is hooked onto the bed side rail at a point that the bag is above the bladder. V11 removed R185's incontinent brief, the brief had stool smears, with a wash cloth that was moistened with peri-wash and water V11 wiped R185's pubic area and left groin, V11 rolled R185 onto her side, and with another wash cloth that was moistened with peri-wash and water, cleansed R185's rectal area and buttocks. V11 did not cleanse or spread the labia, cleanse the urethra opening, indwelling catheter tubing, or dry R185 after the care. On 3/11/25 at 2:10 PM, V11 was questioned why she did not cleanse or spread the labia or dry R185 on 3/10/25, V11 stated, because I was by myself and she is a bigger lady. On 3/13/25 at 9:18 AM, V2, Director of Nurses, stated, catheter care should be complete, spreading the labia, and cleansing the catheter tubing. The policy Catheter Care / Incontinent Care, dated 8/1/05, documents, Procedure: 5. Turn or assist resident to back lying position. 6. Expose genitalia. 7. Put on clean gloves. 8. Cleanse peri area or if appropriate. Cleanse area of insertion of catheter into meatus using clean washcloth prepared with soap and water. Cleanse downward from top to bottom giving care to cleanse the catheter when applicable. Use a clean wash cloth for each swipe down. 9. Rinse well with clean cloth. 10. Dry with clean towel. 44967 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R51's Admission Record, undated, documents R51 was admitted to the facility on [DATE] with diagnosis of Morbid Obesity, Urinary Tract Infections (UTI), Acute Cystitis, Hydronephrosis, Anxiety Disorder, and Extended Spectrum Beta Lactamase (ESBL). R51's Care Plan, dated 1/10/25, documents R51 has a catheter related to Hydronephrosis with Renal and Ureteral Calculous Obstruction. Interventions: Position catheter bag and tubing below the level of the bladder and away from entrance room door. It continues R51 is at risk for an ADL Self Care Performance Deficit Generalized muscle weakness. R51's MDS, dated [DATE], documents R51 is cognitively intact and is dependent on staff for toileting. On 3/11/25 at 11:20 AM, V9, CNA, and V7, CNA, performed incontinent care on R51 with no Personal Protective Equipment (PPE), except gloves, while on Enhanced Barrier Precautions. Supplies brought to bedside, including a bucket of soapy water and washcloths. R51's incontinent brief was unfastened and V9 got a wet washcloth from the water and wiped R51's urinary catheter from urethra opening down the catheter, then got another wet washcloth out of the water and wiped R51's left groin, then with another wet washcloth and wiped down R51's vagina twice. R51 was rolled to her right side while V9 got wet cloth and wiped R51's left buttock and anal area. V9 placed a clean incontinence brief under R51 and rolled her to her back and the brief was fastened. There was no drying of R51, no cleaning of R51's right groin, buttock or hip, and no wiping under abdominal fold. Both CNAs used their soiled gloves to put R51's clean incontinence brief on, her pants put on, placed the full body mechanical lift device sling under her, then R51 requested to take her nightgown off and put a shirt on and both CNAs did this still with their soiled gloves on. Both CNAs doffed gloves and left the room with no hand hygiene seen done. 3. R60's Admission Record, undated, documents R60 was admitted to the facility on [DATE] with diagnosis of Parkinson's Disease, Depression, Transient Ischemic Attack (TIA)/Cerebral Vascular Infarction without residual deficits, and Falls. R60's Care Plan, dated 1/10/25, documents R60 is at risk for an Activities of Daily Living (ADL) Self Care Performance Deficit related to Parkinson's. It continues R60 has had actual falls with intervention of frequent toileting every two hours. R60's Minimum Data Set (MDS), dated [DATE], documents R60 had a moderate cognitive impairment and is dependent on staff for toileting, bathing, and transfers. On 3/11/25 at 9:25 AM, V7, Certified Nursing Assistant (CNA), assisting R60 to get out of bed and dressed. R60 had a strong smell of a bowel movement (BM) noted. V7 assisted R60 to the restroom and pivoted R60 to the toilet. Upon removing R60's incontinence brief, a large BM was seen. While R60 was finishing on the toilet, V7 had the water running in the sink with half of a towel in the sink. After R60 finished, V7 took the towel out of sink, donned gloves, and took the wet part of the towel to the toilet and wiped R60's buttock and anal area, then used the same gloves to put on a clean incontinence brief on R60 and pulled up his pants, then assisted him back to his wheelchair. V7 did not wipe the front or sides of R60 at all. V7 doffed her gloves and pulled R60 to the sink to wash his face. V7 did not do hand hygiene after doffing gloves or leaving the room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 10:25 AM, V1, Administrator, stated I would expect the staff to provide timely and complete incontinent care, including proper hand hygiene and glove changes when soiled. 32874 4. On 03/12/25 at 8:40AM during incontinent care V16, activities assisted V14 CNA to stand R40 with use of gait belt in R40's bathroom. With R40 holding on to grab bar by stool V14 CNA removed R40's adult diaper. R40 incontinent of stool. V14, CNA with wet cloth with cleanser reached between R40's legs from the back and swiped from the front to the back. V14 did not cleanse bilateral groin or separate the labia. V14 cleansed rectal area and dried all areas. V14 did not cleanse buttocks. R40's care plan dated 10/23/2024 documents R40 at risk for ADL (Activity Daily Living) related to disease process. R40's care plan documents the intervention dated 10/23/2024 toilet use requires staff participation to use the toilet. R40's Minimum Data Set (MDS) dated [DATE] documents R40 requires supervision with toileting, and R40 is frequently incontinent of stool. 5. On 03/12/25 at 09:15 AM during incontinent care with R20 in bed on her back. V11, CNA removed adult diaper wet as verified by V11. V11 with wet wash cloths with shampoo body wash on washcloths. With soaped wet washcloth V11 wiped across R20's perineal area. V11 then cleansed bilateral groin. V11 did not separate or cleanse R20's labia. V20 did not rinse R20 prior to drying. V11, CNA then turned R2 to left side and cleaned and dried R20. R20 was not rinsed prior to drying. R20's MDS dated [DATE] documents R20 is frequently incontinent of urine R20's MDS documents R20 is dependent on staff for toileting. The facility policy Perineal Care Policy and Procedure dated, revised 11/2016 documents residents who require assistance from nursing staff to cleanse perineal area will be cleansed in a manner that decreases the risk of transmission of infection and promotes skin integrity. The policy documents perineal care includes care of the external genitalia and anal area and will be performed by a nurse or nurse's assistant. The policy documents for female genitalia- use gentle downward strokes from the front to the back of the perineum, using a clean section of the washcloth or premoistened wipe with each stroke. The policy documents if soap and water used, use clean, wet washcloth to rinse perineal area, using same motion as you did with cleansing, ensuring clean section of the washcloth or pre moistened wipe is used with each stroke. Pat dry resident's perineal area with a dry towel. Turn the resident on their side or in a position comfortable to resident to cleanse rectal area, cleanse rinse, and pat dry the anal area in the same manner you cleansed the perineal area, using strokes that work away from the urethra opening. If needed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to assess an dialysis access for 1 of 1 resident (R21) reviewed for dialysis in the sample of 42. Findings include: R21's Face Sheet, print date of 3/12/25, documents R21 was admitted on [DATE] and has a diagnosis of Dependence on Renal Dialysis. R21's Physician Order, dated 5/1/24, documents, Dialysis @ (DIALYSIS CENTER) TUES-THUR-SAT mornings. R21's Pre/ Post Dialysis Evaluation, dated 3/4/25, documents Treatment Information: Post-Dialysis Evaluation. Time back in facility: 03/04/2024 11:45 AM Treatment performed off-site. Transported by facility transport. Access site: Access site location: LUE (Left Upper Arm) Skin: WNL (within normal limits). No prolonged bleeding. Catheter / port intact: Yes. Catheter / port intact: Yes. Warmth at Site: No. Decreased circulation distal from site: No. Bruit: positive. Thrill: Yes. Dressing dry / intact: Yes. Skin color is WNL. Skin warm / dry to touch. Normal skin turgor. Completed Clinical Suggestions: (no documentation entered) R21's Pre/ Post Dialysis Evaluation, dated 1/25/25, documents, Treatment Information: Post-Dialysis Evaluation. Time back in facility: 01/25/2025 11:47 AM Treatment performed off-site. Transported by facility transport. Access site: Access site location: LUE Skin: WNL. No prolonged bleeding. Catheter / port intact: Yes. Catheter / port intact: Yes. Warmth at Site: No. Decreased circulation distal from site: No. Bruit: positive. Thrill: Yes. Dressing dry / intact: Yes. Skin color is WNL. Skin warm / dry to touch. Normal skin turgor. Completed Clinical Suggestions: (no documentation entered) R21's Electronic Medical Record fails to document any other assessments of R21's Left Upper Arm fistula between 1/25/25 and 3/4/25 and 3/4/25 and 3/12/25. On 3/12/25 at 3:20 PM, V22, Licensed Practical Nurse, stated I do assess fistula sites. V22 was questioned where that is charted, V22 stated usually you chart that in the Medication or Treatment Record, but it is not on R21's. On 3/12/25 at 3:40 PM, V1, Administrator, stated, dialysis fistulas should be assed at least every shift. The Pre and Post Dialysis evaluation should be done after every dialysis session. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Care of a Resident Receiving Hemodialysis, undated, documents, Monitoring Procedures 1. Medications as ordered per physician - Notify Nephrologist of changes 2. Monitor Dialysis site q (every) shift and return from dialysis for bleeding and redness.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to do a complete assessment of bed rails, obtain a Physician Order and consent for bed rails for 3 of 3 residents (R1, R42, R185) reviewed for bed rails in the sample of 42. Findings include: 1. R42's Face Sheet, print date of 3/12/25, documents R42 was admitted on [DATE] and has Hemiplegia and Hemiparesis following a stroke and Epilepsy. R42's Minimum Data Set (MDS), dated [DATE], documents that R42 is moderately cognitively impaired, is dependent on staff for bed mobility, and does not have bed rails. R42's Bed Rail Evaluation, dated 11/22/24, documents R42 has bilateral half bed rails and no other alternative attempted or considered. This Bed Rail Evaluation fails to document the medical reason related to the use of bed rails and the risks associated with the use of bed rails. R42's Care Plan, dated 12/7/23, documents, (R42) is at risk for an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) hemiparesis / hemiplegia. Intervention: Bed Mobility: (R42) requires assistance of 1 with the use of side rails. On 3/11/25 at 10:04 AM, R42 is in bed with half bed rails raised. V25, Certified Nurses Aide, stated that R42 does try to use them when he is being turned. 2. R1's Face Sheet, print date of 3/12/25, documents R1 was admitted on [DATE] and has diagnoses of pneumonia and Congestive Heart Failure. R1's MDS, dated [DATE], documents R1 is cognitively intact, requires substantial assistance with bed mobility, and does not use bed rails. R1's Bed Rail Evaluation, dated 2/17/25, documents R1 has bilateral quarter bed rails and no other alternative attempted or considered. This Bed Rail Evaluation fails to document the medical reason related to the use of bed rails and the risks associated with the use of bed rails. R1's Electronic Medical Record fails to document a Physician Order for the use of bed rails. On 3/12/25 at 8:15 AM, R1 is in his bed with bilateral side rails raised eating breakfast. 3. R185's Face Sheet, print date of 3/12/25, documents R185 was admitted on [DATE] with a diagnosis of History of Falling. R185's Clinical Admission, dated 3/6/2025, documents, Mental Status: Resident is confused. Oriented to person. Confused: Chronic. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Level of cognitive impairment: Moderate impairment (memory loss). Resident is coherent. Speech is clear. Language barrier: No Genitourinary: Ostomy (including urostomy, ileostomy, and colostomy). Urinary catheter intact. Urine amber in color. Urine retention noted. Genitourinary Note: Hospital stated resident has urinary retention. R185's Bed Rail Evaluation, dated 3/6/25, documents R185's medical diagnosis / reason for bed rails is confusion. R185's Electronic Medical Record fails to document a consent or a Physician Order for the use of bed rails. On 3/12/25 at 8:33 AM, R185 is lying in bed asleep with the bilateral side rails raised. On 3/13/25 at 9:50 AM, V12 Restorative Licensed Practical Nurse, stated, there should be a medical diagnosis for the reason the side rails are being used documented. Confusion is not a proper diagnosis for side rails. Every side rail has a risk, and it should be documented on the evaluation. The policy Resident Care Policy and Procedure, dated 1/10/18, documents, Prior to the use of be rails for a resident, the facility will document assessment of use, obtain physician order for use, and obtain consent from the responsible party or POAHC. (Power of Attorney for health Care).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to provide a Physician prescribed antibiotic for 1 of 18 resident (R185) reviewed for medications in the sample of 42. Findings include: R185's Face Sheet, print date of documents that R185 was admitted on [DATE] and has a diagnosis of Pneumonia. R185's Hospital Discharge Plan, dated 3/6/25, documents R185 was in the hospital for Pneumonia. R185's Hospital Medication discharge Report, dated 3/6/25, documents, New Medications: amoxicillin - clavulanate (Augmentin 875 mg (milligram) - 125 mg oral tablet) 1 tab (s) Oral every twelve hours for 3 days. R185's Physician Orders, dated March 2025, fails to document amoxicillin - clavulanate (Augmentin 875 mg (milligram) - 125 mg oral tablet) 1 tab (s) Oral every twelve hours for 3 days. On 3/11/25 at 11:30 AM, V2, Director of Nurses, stated that the hospital discharge orders for Augmentin did not get transferred over to the admitting orders that is why R185 did not receive the Augmentin. On 3/13/25 at 8:02 AM, V8, Physician, stated (R185) was probably on IV (intravenous) antibiotics in the hospital. When they discharged her, they probably just wanted to finish her up on the oral antibiotics. It didn't hurt her to cut the antibiotics short. I do expect the facility to transcribe the hospital discharge orders as they are written so all the medications are continued. The policy Physician Orders, dated 5/2022, documents, It is the policy of this facility to maintain current physician orders to provide treatment according to the attending physician for each resident in the facility. a) All medications and treatments shall be given only upon the written order of the physician. All such orders shall be written in the medical record and shall be given as prescribed by the physician at the designated times.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on Interview and Observation the facility failed to properly store medications for 4 of 11 residents (R27, R30, R48, R237) observed for proper medication storage in the sample of 42. The Findings Include: 1. The 300-North Hall Medication Cart was Reviewed with V4, Registered Nurse (RN). Basaglar Insulin Pen was seen in the cart and was opened with no resident label, name, or the date it was opened. On 3/10/25 at 12:15 PM, V4 stated There are only a few residents who are on that insulin, so I'm sure I can narrow it down to who's it is. The label must have fallen off. 2. On 3/10/25 at 11:00 AM, R27 was seen lying in bed with a medicine cup sitting on his bedside table with 7 pills in the cup. R27's Medication Administration Record (MAR), dated March 2025, documents R27 received the following medications on 3/10/25 at 8:00 AM: ASA 81 MG (milligram), Atorvastatin 40 MG, Cetirizine 10 MG, Famotidine 20 MG, Iron 325 MG, Folic Acid 1 MG, Lisinopril 10 MG, Metoprolol 25 MG, Magnesium Oxide 400 MG. R27's Minimum Data Set (MDS), dated [DATE], documents R27 is cognitively intact. On 3/10/25 at 12:50 PM, V4, RN, stated I always make sure the resident takes all of their meds before leaving the room. There are very few people I trust here that would take their pills if not. On 3/11/25 at 9:23 AM, V7, CNA, stated It's a common thing around here to find a cup of medications left in a resident's room for them to take. 3. On 3/11/25 at 9:20 AM, R237 had a bottle of Pepto-Bismol sitting on his dresser. R237 does not have an order for this. R237's MDS, dated [DATE], documents R237 is cognitively intact. 50908 4. R30 was admitted to the facility on [DATE] with diagnosis of, in part, Parkinson's disease, type two diabetes mellitus, and hypertension. On 3/10/25 at 10:35 AM, R30 had a cup with medications in it sitting on his bedside table. R30 stated the medications were his morning doses, the nurse usually just leaves it there for me to eventually take. (continued on next page)

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	146139	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care	2120 West Washington Springfield, IL 62702

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. R48 was admitted to the facility on [DATE] with diagnosis of, in part, femur fracture, type two diabetes mellitus, and hypertension. On 3/10/25 at 10:11 AM, R48 had a cup of medications on her bedside table. R48 stated the medications were left there this morning by the nurse because she was running late. The Facility's Medication Storage Policy, dated 5/23/24, documents Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. The Facility's Medication Administration Policy, dated 1/11/10, documents It is the policy of this facility to accurately administer medication following physician's orders. 13. Make sure the resident takes the medication. Generally, do not leave meds at bedside (may be exceptions after thorough assessment and care planning).

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33112 Based on interview, observation, and record review, the facility failed to serve palatable food. This failure has the potential to affect all 87 residents residing in the facility. Findings include: 1.On 3/12/25 at 11:20 AM the kitchen was entered. The food thermometer was calibrated to 32 degrees. The noon meal was on the steam table. The garlic butter chicken was 151 degrees, the ground chicken was 186 degrees, the pureed chicken was 150 degrees, the whole sweet potato was 172.5 degrees, the cubed sweet potatoes was 168 degrees, the pureed sweet potato 175 degrees, the cauliflower was 176 degrees, the pureed cauliflower was 177 degrees, gravy 169 degrees, rice was 194 degrees. At 11:34 AM the kitchen service started. The first 300 hall cart went out to the hall at 11:47 AM. The second 300 hall cart went out to the hall at 11:58 AM. The 300 hall trays were all delivered at 12:20 PM. The 100 hall cart was delivered at 12:12 PM. The 100 hall trays were all delivered at 12:28 PM. The 200 hall cart was delivered at 12:14 PM. The 200 hall trays were all delivered at 12:36 PM. The dining room cart was delivered at 12:22 PM. The dining room trays were all delivered at 12:36 PM. On 3/12/25 at 12:36 PM a test tray was sampled. The chicken was 106 degrees. The chicken was dry, tough, and bland. It tasted cold. The cauliflower was 124 degrees. It tastes lukewarm. The cubed sweet potatoes were 117 degrees and they tasted warm and bland. On 3/13/25 at 9:35 AM, V1, Administrator, stated it seems like it is a staffing delivery issue of the trays and that is why the food is cold. We do not have policy on palatable food. The Resident Council Meeting Minutes, dated 9/26/24, documents, Food continue to be overcooked. The Resident Council Meeting Minutes, dated 11/27/24, documents, Residents state the food is cold. The Resident Council Meeting Minutes, dated 1/31/25, documents, Residents state the vegetables are overcooked. Residents state the noodles are overcooked. Residents state the food temperature is not consistent and is often lukewarm when they receive it. The Long Term Care Facility Application for Medicare and Medicaid, dated 3/10/25, documents the facility has 87 residents residing in the facility. 2. On 3/10/25 at 10:10 AM, R51 stated the food is Shi**y here and is usually cold. 3.On 3/11/25 at 9:10 AM, V7, Certified Nursing Assistant (CNA), stated We get a lot of the residents complaining that their food is cold, and we just heat it up for them. It's hard to keep the food warm until they get it. We don't have enough people to hand the trays out fast enough. 4. On 3/11/25 at 12:05 PM, R51's lunch tray was delivered to her room and placed on her bedside table. R51 was not in her room and was in therapy. When R51 returned, she stated her food was already cold and V7 heated it up for her. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. On 3/11/25 at 12:08 PM, V7, CNA, was seen warming up R27's lunch plate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33112 Based on interview, observation, and record review, the facility failed to dry dishware before use. This failure has the potential to affect all 87 residents residing in the facility. Findings include: On 3/12/25 at 11:34 AM the kitchen service began. At 11:51 AM, the trays and the dish covers were noted to be wet. The napkin was getting wet and water drops from the dish covers were potentially dropping onto the food. V21, Dietary Aide, confirmed the trays were wet. V19, Cook, stated they probably did not get shook out enough to dry. On 3/12/25 at 1:40 PM, V1, Administrator, stated Now that I am overseeing the kitchen I have realized that I need to order more supplies because there just isn't enough time in between the meals for things to dry. On 3/13/25 at 9:35 AM, V1, stated We do not have policy on palatable food or drying dishes. The Long Term Care Facility Application for Medicare and Medicaid, dated 3/10/25, documents the facility has 87 residents residing in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interview, observation, and record review, the facility failed to place residents on Enhanced Barrier Precautions, wear Personal Protective Equipment, perform hand hygiene and change gloves when needed for 3 of 16 residents (R74, R51, R60) reviewed for infection control in the sample of 42. Findings Include: 1. R74 was admitted to the facility on [DATE] with diagnosis of, in part, sepsis due to enterococcus, hydronephrosis with ureteropelvic junction obstruction, and emphysema with a history of methicillin susceptible staphylococcus aureus infection. On 3/11/25 at 12:55 PM, V5 LPN provided nephrostomy care to R74 and emptied her urine bag without a gown on. There was an enhanced barrier precautions (EBP) sign and supplies outside R74's door. V5 stated R74 is on EBP and she should have been wearing a gown while providing R74 care. The Enhanced Barrier Precautions Protocol, undated, documents, Enhanced Barrier Precautions expands the use of Personal Protective Equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for the transfer of Multi-Drug Resistant Organism (MDROs) to staff hands and clothing. If Enhanced Barrier Precautions are required, a sign should be placed outside the resident's room to assist in education staff, residents, and visitors, on appropriate personal protection. When required, Enhanced Barrier Precautions apply to everyone caring for treatment. Personal Protective Equipment. Hand hygiene must be followed. PPE (gown and gloves) should be used during high contact resident care activities. Examples of high contact resident care activities requiring gown and glove use include: Dressing. Bathing / Showering. Transferring. Provide hygiene. Changing lines. Changing briefs or assisting with toileting. Device care of use: central line, urinary catheter, feeding tube, tracheostomy / ventilator. Wound care: any skin opening requiring a dressing. 44967 2. R51's Admission Record, undated, documents R51 was admitted to the facility on [DATE] with diagnosis of Morbid Obesity, Urinary Tract Infections (UTI), Acute Cystitis, Hydronephrosis, Anxiety Disorder, and Extended Spectrum Beta Lactamase (ESBL). R51's Care Plan, dated 1/10/25, documents R51 has a catheter related to Hydronephrosis with Renal and Ureteral Calculous Obstruction. Interventions: Position catheter bag and tubing below the level of the bladder and away from entrance room door. It continues R51 is at risk for an ADL Self Care Performance Deficit Generalized muscle weakness. R51's MDS, dated [DATE], documents R51 is cognitively intact and is dependent on staff for toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 11:20 AM, V9, CNA, and V7, CNA, performed incontinent care on R51 with no Personal Protective Equipment (PPE), except gloves, while on Enhanced Barrier Precautions. Supplies brought to bedside, including a bucket of soapy water and washcloths. R51's incontinent brief was unfastened and V9 got a wet washcloth from the water and wiped R51's urinary catheter from urethra opening down the catheter, then got another wet washcloth out of the water and wiped R51's left groin, then with another wet washcloth and wiped down R51's vagina twice. R51 was rolled to her right side while V9 got wet cloth and wiped R51's left buttock and anal area. V9 placed a clean incontinence brief under R51 and rolled her to her back and the brief was fastened. There was no drying of R51, no cleaning of R51's right groin, buttock or hip, and no wiping under abdominal fold. Both CNAs used their soiled gloves to put R51's clean incontinence brief on, her pants put on, placed the full body mechanical lift device sling under her, then R51 requested to take her nightgown off and put a shirt on and both CNAs did this still with their soiled gloves on. Both CNAs doffed gloves and left the room with no hand hygiene seen done. On 3/13/25 at 10:25 AM, V1, Administrator, stated I would expect the staff to provide timely and complete incontinent care, including proper hand hygiene and glove changes when soiled. 3. R60's Admission Record, undated, documents R60 was admitted to the facility on [DATE] with diagnosis of Parkinson's Disease, Depression, Transient Ischemic Attack (TIA)/Cerebral Vascular Infarction without residual deficits, and Falls. R60's Care Plan, dated 1/10/25, documents R60 is at risk for an Activities of Daily Living (ADL) Self Care Performance Deficit related to Parkinson's. It continues R60 has had actual falls with intervention of frequent toileting every two hours. R60's MDS, dated [DATE], documents R60 had a moderate cognitive impairment and is dependent on staff for toileting, bathing, and transfers. On 3/11/25 at 9:25 AM, V7, Certified Nursing Assistant (CNA), assisting R60 to get out of bed and dressed. R60 had a strong smell of a bowel movement (BM) noted. V7 assisted R60 to the restroom and pivoted R60 to the toilet. Upon removing R60's incontinence brief, a large BM was seen. While R60 was finishing on the toilet, V7 had the water running in the sink with half of a towel in the sink. After R60 finished, V7 took the towel out of sink, donned gloves, and took the wet part of the towel to the toilet and wiped R60's buttock and anal area, then used the same gloves to put on a clean incontinence brief on R60 and pulled up his pants, then assisted him back to his wheelchair. V7 did not do hand hygiene after doffing gloves or leaving the room. The Facility's Hand Hygiene Protocol Policy, dated 7/26/21, documents Cleaning your hands reduces: The spread of potentially deadly germs to residents; The risk of healthcare provider colonization or infection caused by germs acquired from the resident. During routine resident-care: Use an Alcohol-Based Hand Sanitizer: Before resident contact, before moving from work on a soiled body site to a clean body site on the same resident, after touching a resident or the resident's immediate environment, after contact with blood body fluids or contaminated surfaces, immediately after glove removal, and prior to leaving resident's room. Wash with Soap and Water: When hands are visibly soiled, after assisting resident with toileting (e.g., bedpan, urinal, restroom).