STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146142	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Village Care Center	27 Auerbach Place Glen Carbon, IL 62034

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 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** 44953 Based on interview and record review the facility failed to provide preventative measures for a safe transfer, free of hazards from one level to the next for 2 out of 8 residents (R39, R59) for falls in a sample of 43. 1. R59's Face Sheet undated documents her pertinent diagnosis as age related physical debility and repeated falls. R59's Minimum Data Set (MDS) dated [DATE] documents R59 has moderate cognitive impairment and is dependent in transferring from sit to stand, chair to bed, toilet, and tub transfer. R59's Fall Risk admitted d 7/26/24 documents High Risk for Falls. Nurse Progress notes dated 11/6/24 documents R59 lost her balance during a transfer from wheelchair to recliner and fell to her right side, staff was present with her. Medical records from an area hospital dated 11/6/24 documents R59 presenting with a ground level fall during transferring a patient, head injury, bruising to forehead, forehead hematoma. 11/6/24 CT with spine obtained documents no acute abnormality, no acute intracranial finding. On 11/21/24 at 12:23 PM, V27 (Certified Nursing Assistant/CNA) stated she was the CNA involved in the transfer of R59 on 11/6/24. V27 stated it was after lunch and she was in the process of transferring R59 to her recliner, she stood R59 up using a gait belt and R59 fell forward. R59 is top heavy. V27 stated she did use a gait belt and was positioned behind R59, tried to hold onto her but could not prevent her fall. She had transferred R59 before and had not had any problems with transferring her. V1 (Administrator) had provided in-service training on the correct way to transfer residents. On 11/21/24 at 12:47 PM, V28 (Certified Occupational Therapy Assistant) stated when using a gait belt with a resident you position yourself in front of the resident to help guide them and prevent resident from falling over. On 11/22/24 at 1:31 PM, V1 (Administrator) stated R59 was new to the facility and had not been assessed by physical therapy for an assistive device for mobility. V1 stated she was unaware of the positioning of the CNA with the gait belt that contributed to R59's falling over during transfer. V1 stated V1 had provided in-service training on transfers to the CNA. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45947 2. R39's Face Sheet documents R39 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, polyneuropathy, heart failure, and fatigue. R39's Minimum Data Set (MDS) dated [DATE] documented R39 was cognitively intact, required substantial assistance with rolling from side to side, and was dependent with transfer. R39's Morse Fall Scale dated 6/4/24 documents R39 was at risk for falls. The Facility's Fall Log documents R39 had falls on 6/20/24 and 6/28/24. R39's Adverse Event Documentation dated 6/20/24 documents R39 fell out of bed, hit his head and nose, and sustained a bruise and hematoma to his forehead. R39 was admitted to the hospital with skull and facial fractures, trace subarachnoid hemorrhage, and small parafalcine subdural hematoma. R39's Adverse Event Documentation dated 6/28/24 documents staff were getting ready to mechanically lift R39 from his wheelchair to bed, and when they removed his footrest, he slid to the floor with his back against the wheelchair. On 11/21/24 at 10:05 AM, V26 (Registered Nurse) stated she did not witness R39's 6/28/24 fall but was notified by V30 and V31 (CNAs) that he had fallen when they were preparing to transfer him via mechanical lift. She stated R39 was supporting himself with the footrest because of the way he was positioned, and when they moved the foot pedals out, he slid down from the chair. On 11/21/24 at 2:00 PM, V30 (CNA) stated she was assisting with (R39's) transfer from wheelchair to bed and did not realize he was supporting himself with the foot pedals on his wheelchair. R39's sling was underneath him but was not yet hooked up to the lift. They moved the foot pedals out, and he slid from the chair to a seated position on the floor. She stated they probably could have prevented this if they had repositioned him or hooked the sling to the lift before removing the foot pedals. On 11/21/24 at 2:17 PM, V31 (CNA) stated she was removing R39's foot pedals from his wheelchair before hooking his sling to the mechanical lift when he started to slide. She was standing behind him and helped lower him to the ground to a seated position. She stated he was slouched to one side in his chair and the foot pedals were keeping him in place, and the moment she took the pedals away he started to slide down. She stated better positioning in his chair may have prevented this from happening. On 11/22/24 at 9:20 AM, V1 (Administrator) stated she expects staff to ensure residents are positioned properly prior to transfer. The facility policy Management of Fall Risk with a review date 1/30/24 documents the definition of a fall is an incident in which the resident unintentionally comes to rest on the ground, floor, or other lower level. Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try prevent the resident from falling from falling and to try to minimize complications from falling.

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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. 45947 Based on observation, interview, and record review, the Facility failed to ensure food was prepared according to physician prescribed diet orders for 3 of 3 residents (R6, R38, R47) reviewed for therapeutic diets in the sample of 43. Findings include: 1. R6's Physician Order dated 9/21/24 documents, Diet: IDDSI (International Dysphagia Diet Standardization Initiative) Level 5 Minced & Moist. On 11/19/24 at 12:20 PM, R6 was eating lunch in the dining room. R6's ground chicken did not have a sauce or liquid on top to moisten it. 2. R38's Physician Order dated 1/24/24 documents, Diet IDDSI Level 5 Minced & Moist. On 11/19/24 at 12:14 PM V15 (Licensed Practical Nurse) was assisting R38 with her lunch in the dining room. R38's ground chicken did not have a sauce or liquid on top to moisten it. 3. R47's Physician Order dated 5/5/24 documents, Diet IDDSI Level 5 Minced & Moist. On 11/19/24 at 12:20 PM R47 was eating lunch in the dining room. R47's ground chicken did not have a sauce or liquid on top to moisten it. On 11/19/24 at 12:25 PM V7 (Dietary Aid) stated the cooks have not been preparing sauces or gravies for the mechanically altered diets lately. On 11/19/24 at 3:00 PM, V4 (Dietary Manager) stated all mechanical soft diets should come with some sort of liquid or gravy. On 11/20/24 at 3:30 PM, V17 (Speech Language Pathologist) stated minced and moist meats should be covered with a sauce or gravy or some kind of liquid to ensure the food stays moist. On 11/22/24 at 9:20 AM, V1 (Administrator) stated she expects staff to follow food service policies and physician prescribed diets. The Facility's Therapeutic and Mechanically Altered Diets - Long Term Care Policy reviewed 2/16/24 documents, The CDM (Certified Dietary Manager) and Dining Services supervisor will establish and use and identification system to ensure that each resident receives their diet as ordered. Staff should be trained on the system to ensure that correct procedures are followed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on observation, interview, and record review, the Facility failed to ensure food was stored and prepared in a manner that prevents foodborne illness. This has the potential to affect all 62 residents living in the Facility. Findings include: On 11/19/24 at 8:27 AM in the standing freezer there were open bags of hash browns, chicken strips, onion rings, egg rolls, French fries, and chicken drumsticks. These bags were not labeled, dated, or resealed upon opening, leaving the contents open to air. There was an opened package of pepperoni that was not dated or resealed upon opening, leaving the contents open to air. There was a bag of fish and a bag of raw chicken breasts that were labeled and dated upon opening, but were not resealed, leaving the contents open to air. The bag of raw chicken breasts was stored directly above a box of shrimp which had also been opened but was not dated. On 11/19/24 at 8:30 AM in the standing refrigerator to the right of the standing freezer, there were two gallons of skim milk labeled Best by [DATE]. There was a box of brown, unpasteurized shell eggs stored directly above cartons of liquid pasteurized eggs. There was a container with a red liquid substance that was not labeled or dated. V5 (Dietary Supervisor) stated it was tomato soup, and she thinks it was made yesterday. There was a half full container of commercially made tuna salad that was not dated upon opening. There was a container with an unknown substance that V5 stated was creamed corn that was not labeled or dated. There was a package labeled corned beef dated 11/6. V5 stated food should not be kept for that long. On 11/19/24 at 8:32 AM, V8 (Dishwasher) stated she does not test the sanitizer in the dish machine and has only seen test strips when the maintenance company comes in to check the machines periodically. On 11/19/24 at 8:35 AM in the walk-in refrigerator there was commercially prepared container of tuna salad that had been previously opened. The lid was not sealed, and the container was not dated upon opening. There were containers of onions, tomatoes, and black olives that were not labeled or dated. On 11/19/24 at 8:38 AM in the walk-in freezer there was a plastic bag of corn dogs and a plastic bag of breaded meat that had been removed from the original packaging and were not labeled or dated. On 11/19/24 at 8:41 AM in the dry storage room there was a package of coconut flakes that was not dated upon opening. There was plastic bag of raisins inside a large box that had been opened, but was not resealed upon opening, leaving the raisins open to air. On 11/19/24 at 8:44 AM, V6 (Executive Chef) stated the Facility does make eggs over easy and does not believe the shell eggs they use are pasteurized. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/19/24 at 8:43 AM, holding temperatures were obtained from the steam table on [NAME] Way during breakfast service with a metal calibrated thermometer. The oatmeal measured 125 Fahrenheit (F). V7 (Dietary Aid) was stated he was not sure of the goal temperature but tries to keep the food warm. On 11/19/24 at 9:40 AM, V4 (Dietary Manager) stated they do keep test strips for the dish machine, but V8 just started working that shift as the dishwasher. On 11/22/24 at 9:20 AM, V1 (Administrator) stated she expects staff to follow food service policies. The Facility's Food Storage Policy revised 10/1/20 documents, It is the policy of the Dining Services Department to develop a mechanism to ensure the safe and accurate storage of food and nonfood products. Items that arrive in their original packaging with a manufacturer's expiration date will utilize that date for discard. Should an item be opened and stored in a different container, it will be labeled with an open date and a discard date. Food Safety practices based on Serv Safe Standards will be followed at all times. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 11/19/24 documents there are 62 residents living in the Facility.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 33110 Based on interview and record review the facility failed to provide antibiotic stewardship for 1 of 2 residents (R116) reviewed for antibiotic stewardship in the sample of 43. Findings Include: The facility's Infection Control Log dated 7/2/24 documents R116 prophylactic use admitted with a UTI (Urinary Tract Infection). The Infection Control Log also documented that R116 received Methenamine Hippurate 1 gram. R116's Nurses Note dated 7/9/24 documents V33 (Attending Physician) gave okay to check a UA (Urinalysis) and C&S (Culture and Sensitivity) to R/O (Rule Out) UTI. PT (Patient) cont. (continues) to c/o (complain of) UTI symptoms. She (R116) is on prophylaxis ABX (antibiotic) daily now and UA on 7/3 was neg (negative). Son cont. to request UA. R116's Medication Administration Record for the month of July documents Methenamine Hippurate 1 gram one tablet per day starting 7/1/24 through 7/26/24 UTI Prophylactic. R116 Physician Order Sheet dated 7/1/24 documents Methenamine Hippurate 1 gram tablet oral Indication: UTI Prophylactic. Discontinued on 7/26/24. R116's Infection Care Plan dated 7/9/24 to present documents (R116) is presenting with infection (R116) will be assessed for signs and symptoms of infection. Intervention: chronic use of antibiotic related to methenamine prior to admitting to the facility current active. On 11/22/24 at 1:25 PM V1 (Administrator) stated, she (R116) was admitted on that chronic antibiotic. We did not discontinue it because she was admitted on it. The facility policy Antibiotic Program dated 1/30/24 documents the antibiotic program promotes the appropriate use of antibiotics and a system of monitoring to improve resident outcomes and reduce antibiotic resistance