STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146151	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clayberg, The	625 East Monroe Street Cuba, IL 61427

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 30678 Based on interview and record review, the facility failed to provide notice of transfer for two (R39 and R43) of two residents reviewed for hospitalization in the sample of 23. Findings include: The facility's Bed-Holds and Returns policy and procedure, revised 3/2017, documents, Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail; d. The details of the transfer (per the Notice of Transfer). 1. The Progress Note for R39, dated 9/13/23 at 1:07 pm, documents R39 was taken to the local hospital by facility van for evaluation. The local hospital then transferred R39 to another local hospital. There is no Progress Note documenting the Notice of Transfer was given to R39 or R39's Representative. On 5/12/24 at 6:50 am, R39 stated she had to go to the hospital because she had a stroke and does not recall if she or her family received any paper work from the facility. The EHR (electronic health record) for R39 does not include documentation or scanned forms indicating the Notice of Transfer was completed or provided to R39 or R39's representative. On 5/14/24 at 1:35 pm, V3, ADON (Assistant Director of Nursing), stated the facility only sends out a Bed Hold form with the resident and confirmed the Notice of Transfer is not something given to residents or family's. On 5/14/24 at 1:53 pm, V5, LPN (Licensed Practical Nurse)/Medical Records, stated the facility sends the Bed Hold form, Face Sheet, Physician Orders, Progress Notes, Insurance information and the POLST (Physician Orders for Life-Sustaining Treatment) form with a resident who transfers to the hospital. V5, LPN, confirmed she is not aware of a Notice of Transfer being given to residents or their family. 30722 (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) R43's Medication Review Report, dated 5/14/24, documents he has diagnoses which include a history of Atrial Firbrillation, Chronic Kidney Disease, Dementia and Congestive Heart Failure. R43 was hospitalzied on 01/29/24, 01/31/24, 02/26/24 and 03/15/24. The facility provided a Bed hold notice for these dates regarding R43's hospitalization s however, did not provide notice of transfer or the reason for R43's hospitalization .

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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. 30678 Based on observation, interview, and record review, the facility to prevent cross contamination during a pressure ulcer treatment for one (R31) of one resident reviewed for pressure ulcers in the sample of 23. Findings include: The facility's undated Policy and Procedure for the prevention and treatment of skin breakdown, documents, It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care. The facility's Standard Precautions policy and procedure, revised 1/2012, documents: Standard Precautions will be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) or using alcohol-based hand rubs (gels, foams, rinses) that do not require access to water. Wash hands after removing gloves. Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body sit to another (when moving from a dirty site to a clean one). Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. On 5/13/24 at 9:49 am, V6, RN (Registered Nurse), and V7, CNA (Certified Nursing Assistant), entered R31's enhanced barrier precaution room with gown and gloves on. V6, RN, placed wound treatment supplies onto R31's bed. V6, RN, held R31 onto R31's right side while V7, CNA, provided incontinence care, removing stool from R31's buttock. V7, CNA (Certified Nursing Assistant), held R31 on his right side while V6, RN, picked up gauze and plastic cup from R31's bed, put the gauze into the cup, and sprayed the gauze with wound cleanser to soak gauze. Holding the cup of gauze with her left hand, V6, RN, reached in and pulled the saturated gauze from the cup with her right hand, and proceeded to clean R31's open coccyx wound. Holding the wet soiled gauze in the palm of her right hand, V6, RN, removed gloves off her bilateral hands and threw the gloves in the garbage can. Without performing hand hygiene, V6, RN, retrieved a second pair of gloves, put the gloves on and while holding the tube of ointment in her left hand, squeezed a small amount of the white cream from the tube onto her right index finger. V6, RN, spread the ointment over R31's open coccyx wound bed using her gloved finger, pulled a marking pen from her own uniform pocket, removed the lid, wrote the date on the dressing, put pen back in her pocket and then applied the dressing to R31's coccyx wound. V6, RN, removed her gloves, gathered treatment supplies, arranged R31's bedding, and placed R31's call light in reach, prior to performing hand hygiene. On 5/15/24 at 2:00 pm, V1, Administrator, confirmed V6, RN, should have performed hand hygiene after removing soiled gloves and before touching anything.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30722 Based on observation, interview, and record review, the facility failed to ensure residents receiving antipsychotic medications had relevant clinical indication and diagnosis for the use of antipsychotic medication for five residents (R21, R28, R30, R42, and R43), and failed to include targeted behaviors for one (R42) of five residents reviewed for unnecessary medications in the sample of 23. Findings include: An Antipsychotic Medication Use policy, revised December 201,6 under a section titled Policy Interpretation and Implementation the following: 7. Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions: a. Schizophrenia; b. Schizo-affective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (example bipolar disorder, depression with psychotic features, and treatment refractory major depression); f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (example, high-dose steroids); h. Tourette's Disorder; i. Huntington Disease; j. Hiccups (not induced by other medications); or k. nausea and vomiting associated with cancer or chemotherapy. 8. Diagnoses alone do not warrant the use of Antipsychotic medication In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met a. The behavioral symptoms present a danger to the resident or others; AND: 1) symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or 2) Behavioral interventions have been attempted and included in the plan of care, except in an emergency. 11. Antipsychotic medications will not be used if the only symptoms are one or more of the following: Wandering; b. Poor self-care; c. Restlessness; d. Impaired memory; e. Mild anxiety; f. Insomnia; g. Inattention or indifference to surroundings; h. Sadness or crying alone that is not related to depression or other psychiatric disorders; i. Fidgeting; j. Nervousness; or k. Uncooperativeness. 1. R30's Psychiatry Note, dated 05/06/24, documents a history of Mood Disorder, Generalized Anxiety Disorder, Insomnia, Dementia and Alzheimer's. R30's Psychiatry Note documents R30 is prescribed Aripiprazole 5 milligrams every evening for Mood Disorder, Buspirone 10 milligrams three times daily for Mood Disorder, Escitalopram 15 milligrams every morning for Mood Disorder and Lamotrigine 50 milligrams every morning for Mood Disorder. R30's Psychiatry Note documents, No signs of mania. No signs of psychosis. No problems tolerating medications. Per chart review, (R30) has now resumed her Aripiprazole. Staff document she has shown improvement in agitation, aggression, and resistance to cares since resuming med (medication). 2. R43's Psychiatry Note, dated 05/06/24, documents R4 has a psychiatric history of Dementia. R43's Psychiatry Note documents the order for the following medications: Divalproex Sprinkles 250 milligrams three times daily for behaviors related to Dementia, Quetiapine 12.5 milligrams twice daily for agitation related to Dementia and Quetiapine 50 milligrams every 12 hours as needed for 14 days for breakthrough agitation or aggression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R43's Psychiatry Note documents the following behaviors: Agitation, anxiety, resistance to cares, combativeness. R43's Psychiatry Note further documents, Director of Nursing reports (R43) is more alert since dose reduction and (R43) is very receptive to non-pharma logical interventions to de-escalate disruptive behaviors depending on the approach. On 5/15/24 at 11:22 am, V10, MDS Coordinator, and V11, SSD, stated they work on the psychotropic medications together, and antipsychotics should be used for residents with psychotic diagnoses like Schizophrenia and Bipolar. V10, MDS Coordinator, confirmed R30 and R43 do not have an appropriate diagnosis for the use of their antipsychotic medication and should have. 49187 3. R21's current Admission Record documents R21 has an admitted [DATE]. R21's Physician Orders, dated 9/27/23, documents R21 has received Seroquel (anti-psychotic medication) 50mg (milligrams) by mouth at bedtime for the diagnosis of Dementia with agitation. R21's MDS (Minimum Data Set) Assessment, dated 3/6/24, documents R21 is severely cognitively impaired and has no behavioral symptoms that impact the resident or others, cause significant risk of injury to herself or others, or interfered with R21's care. R21's Care Plan, dated 5/13/24, documents R21 receives Seroquel for Dementia with agitation. R21's Psychiatry Note, dated 4/8/24, documents R21 receives Seroquel for agitation related to Dementia. This same form documents R21's mood and behavior remain stable, and no symptoms of psychosis or mania were observed or reported. R21's Behavior Monitoring and Interventions Report, dated 2/1/24 to 4/30/24, documents R21 had only one behavior of grabbing others and being physically aggressive towards others on 2/1/24. This same report had no documentation of any other behaviors occurring during that time frame. On 5/12/24 at 8:00 am, R21 was sitting in R21's wheelchair at a table in the dining room. R21 was preparing to eat breakfast. R21 had no behaviors at this time. On 5/13/24 at 11:15 AM to 11:30 am, R21 was in R21's wheelchair at a table in the dining room. V15 (CNA/Certified Nursing Assisting) was assisting feeding R21 lunch. R21 had no behaviors at this time. On 5/13/24 at 11:35 am, V15/CNA stated she has not witnessed any aggressive behaviors from R21. On 5/13/24 at 1:00 pm, V9/CNA stated R21 has pinched and hit her a couple of times during transfers or cares, but it hasn't happened for a while. V9 stated, That is the only behaviors I have witnessed from (R21). 4. R42's Admission Record documents R42 has an admitted [DATE]. R42's Physician Orders, dated 5/7/24, documents R42 has received Olanzapine (anti-psychotic medication) 2.5mg (milligrams) by mouth at bedtime for the diagnosis of mood disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R42's MDS (Minimum Data Set) Assessment, dated 4/9/24 documents R42 is moderately cognitively impaired and has no behavioral symptoms that impact the resident or others, cause significant risk of injury to himself or others, or interfered with R42's cares. R42's Psychiatry Note, dated 5/6/24, documents R42 receives Olanzapine for Dementia with behaviors. This same form documents no mood or behavior concerns. R42's Care Plan, dated 5/7/24, documents R42 is being treated with Olanzapine (anti-psychotic medication) related to Major Depressive Disorder. This same care plan does not include the targeted behaviors or non-pharmacological interventions to address targeted behaviors for the use of R42's Olanzapine. R42's Behavior Monitoring and Interventions Report, dated 2/1/2024 to 4/30/2024, documents R42 had behaviors of being withdrawn on 3/15/24 and 4/6/24, refusing care on 2/6/24 and 4/6/24, and agitation, anxiousness, neglecting self-care, sad and tearful, and insomnia on 4/6/24. This same report had no documentation of any other behaviors occurring during that time frame. On 5/12/24 from 10:20 am to 10:30 am, R42 was sitting in his room in R42's recliner watching television. R42 had no behaviors during this time. On 5/13/24 from 11:45 am to 12:00 pm, R42 was sitting in a chair in the community room waiting to be transported to dialysis. R42 had no behaviors during this time. On 5/14/24 at 11:00 am, V1 (DON/Director of Nursing) stated, I have not witnessed or am I aware of (R42) having any behaviors or aggressiveness. On 5/16/24 at 10:05 am, V5 (LPN/Licensed Practical Nurse) stated, When (R42) first admitted to (the facility) he had some withdrawn behaviors. (R42) was here by himself and then they admitted his wife. (R42) has been much better and I have not witnessed him having those withdrawn behaviors. I have not witnessed any other behaviors from (R42). On 5/15/24 at 11:30 am, V11 (SSD/Social Service Director) stated, I do the mood/behavior care plan. I did not include targeted behaviors for (R42's) Olanzapine because (R42) hasn't been having any behaviors. 30678 5. The Quarterly MDS (minimum data set) Assessment for R28, dated 4/16/24, documents R28 with severely impaired cognition with the following diagnoses: Medically Complex Conditions, Alzheimer's Disease, Non-Alzheimer's Dementia, Depression and Primary Insomnia and R28 received antipsychotic medication on a routine basis. The current Order Summary Report for R28 documents R28 receives the antipsychotic medication Quetiapine 50 mg (milligrams) three times daily for the diagnosis of Behavioral Disturbance. The current Care Plan for R28 documents R28 with impaired thought processes related to Alzheimer's Disease and is being treated for Dementia with behaviors and behavior management with the antipsychotic medication Quetiapine. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/12/24 at 9:00 am, R28 was talking continuously, exhibiting word salad with accusatory statements, and making frowning and furrowed brow faces at others and wandering the hallways. On 5/13/24 at 7:31 am, R28 was sitting in a chair near front lobby yelling as people walked by her, and words not making sense. On 5/14/24 at 9:02 am, R28 was sitting on a sofa in the activity area, talking out loud, words and sentences not making sense, asking questions with various words, and unable to determine what she is asking. The Social Service Note, dated 4/23/24 1:56 pm, R28 is alert to name, exhibits confusion to time, place, date and situation. Short- and long-term memory recall abilities are severely impaired. Communication skills are severely impaired as evidenced by word salad, conversation irrelevant and nonsensical. Exhibits short attention span. Is unable to complete interview. During observation period R28 wandered without leaving facility, had verbal outbursts of yelling and making disruptive sounds. R28 has not displayed and physical behaviors. The facility's Psychiatry service made a note, dated 5/6/24, documents R28 with a history of MDD (Major Depressive Disorder), Dementia, and Alzheimer's with past medical history of Alzheimer's disease, Overactive bladder, GERD, Hyperlipidemia, Type 2 diabetes mellitus, Hypertension, Asthma. On 5/15/24 at 11:22 am, V10, MDS Coordinator, and V11, SSD, stated they work on the psychotropic medications together and antipsychotics should be used for residents with psychotic diagnoses like Schizophrenia and Bipolar. V10, MDS Coordinator, confirmed R21, R28, R30, R42, and R43 do not have an appropriate diagnosis for the use of their antipsychotic medication, and should have.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49187 Based on observation, interview, and record review, the facility failed to ensure an opened multi-dose diabetic insulin pen and an opened multi-dose insulin vial was labeled with the date opened for two of two residents (R11 and R27) reviewed for storage and labeling of medications in a sample of 23. Findings include: The facility's Administration Medication Policy, dated 12/2012, documents, Policy Statement: Medications will be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 9. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. On 5/13/24 at 9:35 am, V4 (LPN/Licensed Practical Nurse) was standing at the medication cart passing medications in the dining room. V4 opened the top right drawer of the medication cart where residents' vials of opened insulin injector-pens and insulin vials were stored. In this drawer, R11's Toujeo (insulin glargine) 300 units/ml (milliliter) multi-dose pen, and R27's Lantus (insulin glargine) was open and without a label indicating the date opened. V4 verified R11's insulin pen and R27's insulin vial had no label with the date opened. On 5/15/24 at 10:02 am, V2 (DON/Director of Nursing) verified all insulin pens and insulin vials should be dated when opened.

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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** 49187 Based on interview, observation, and record review, the facility failed to perform hand hygiene during incontinence care for one of five residents (R3) reviewed for infection control in the sample of 23. Findings include: The facility's Standard Precautions policy, dated 01/2012, documents, Policy Statement: Standard Precautions will be used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain infectious agents. Standard precautions include the following practices: 1 Hand hygiene. a) Hand hygiene refers to handwashing with soapy (anti-microbial or non-antimicrobial) or using alcohol-based hand rubs (gel, foams, rinses) that do not require access to water. d) Wash hands after removing gloves (see below). 2. Gloves. e) Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean one). R3's current Admission Record documents R3 was admitted on [DATE]. This same form documents R3 has a diagnosis of a Urinary Tract Infection starting on 5/3/24. R3's current Order Summary Report documents R3 is on contact isolation precautions due to ESBL/bacterial infection (Extended Spectrum Beta-Lactamase) in her urine. On 5/13/24 at 12:48 pm, V8 (CNA/Certified Nursing Assistant) and V9/CNA were preparing to perform incontinence care on R3. V9 had a bedside table prepared with a basin of water, soap, wash clothes, towels, gloves, and alcohol-based hand gel. V8 and V9 both washed their hands and applied gloves. V9 un-taped R3's incontinent brief and removed it. R3's incontinent brief was soiled with a medium amount of soft BM (bowel movement). V8 assisted holding open R3's legs while V9 wiped R3's perineal area from front to back with a wet soapy washcloth. V9 then removed her gloves, and without performing any hand hygiene, applied new gloves. V9 then took a regular wet washcloth and cleansed R3's perineal area, then grabbed a dry towel and dried R3's perineal area off. V9 then removed her gloves and without performing any hand hygiene applied new gloves. V8 then turned R3 onto R3's left side and V9 then began cleansing R3's rectal area with another wet soapy washcloth. V9 then removed her gloves and without performing hand hygiene applied new gloves. V9 took a regular wet washcloth and began cleansing R3's rectal area, then V9 took a dry towel and dried R3's rectal area off. V9 then removed her gloves and without performing hand hygiene applied new gloves. V9 then assisted V8 with applying a new incontinence brief on R3, getting R3 dressed, and repositioning R3. On 5/14/24 at 12:57 pm, V9/CNA verified she did not perform hand hygiene in between glove changes. V9 stated, I should have used my hand sanitizer (alcohol-based hand gel) in between removing my gloves and applying new gloves during (R3's) incontinence care, especially when going from a dirty to clean site.