STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146157	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Falls Rehab & Hlth Care C	430 Martin Road Rock Falls, IL 61071

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review, the facility failed to issue a bed hold notice to 1 of 1 resident (R8) reviewed for bed holds in the sample of 12. The findings include: R8's face sheet showed a [AGE] year-old female with diagnosis of major depressive disorder, schizoaffective disorder, bipolar type, generalized anxiety disorder, osteoarthritis, bipolar disorder, hypertension, type 2 diabetes, and chronic obstructive pulmonary disease. On 9/3/24 at 9:41 AM, R8 was in a wheelchair seated at a dining room table. There was a book in front of her. R8 had clear speech, good eye contact, was calm and in no distress. On 09/03/24 at 09:41 AM, R8 said I was hospitalized last week. I don't know what they did. They kept me a while and sent me back. R8 said the facility did not issue a bed hold notice to her. On 09/04/24 at 12:52 PM, V2 Director of Nursing (DON) said when a resident is sent out, a face sheet, med list and bed hold policy are sent with. V2 said she could not find a signed bed hold notification in R8's chart. V2 said R8 is a reliable historian. If R8 said she did not receive one, then she didn't receive one. Its important bed hold notifications are issued so the residents know they still have a bed here. R8's 8/1/24 facility assessment showed R8 was cognitively intact. R8's medical record had no documentation a bed hold notice was issued on 8/30/24 prior to going to the emergency room . The facility's 8/1/17 Bed Hold Guarantee Policy showed the resident, resident family or legal representative will be given the appropriate Notice of Bed Hold Policy at the time of discharge or therapeutic leave, if possible, but notice will be given no longer than 24 hours after discharge or initiation of leave.

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

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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 0684 Level of Harm - 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** 35175 Based on observation, interview and record review the facility failed to ensure a resident with a diagnosis of major depressive disorder received medication to treat the disorder. This failure resulted in R8 having suicidal ideation and being sent to a local emergency room for evaluation. The facility also failed to notify a physician and assess a resident (R21) after holding a blood pressure medication. These failures apply to 2 of 2 residents (R8, R21) reviewed for quality of care in the sample of 12. Findings include: 1. R8's face sheet showed a [AGE] year old female with diagnosis of major depressive disorder, schizoaffective disorder, bipolar type, generalized anxiety disorder, osteoarthritis, bipolar disorder, hypertension, type 2 diabetes, and chronic obstructive pulmonary disease. On 9/3/24 at 9:41 AM, R8 was in a wheelchair seated at a dining room table. There was a book in front of her. R8 had clear speech, good eye contact, was calm and in no distress. On 09/03/24 at 09:41 AM, R8 said I was hospitalized last week. I felt suicidal. I don't know what they did. They kept me a while and sent me back. On 09/04/24 at 12:58 PM, V2 Director of Nursing (DON) said I don't know anything about her fluoxetine (antidepressant medication) running out. I'll have to look into it. The resident could have some type of reaction if they don't get their meds as ordered. They could be very depressed and suicidal. At 3:00 PM, V16 Director of Nursing at a sister facility said R8's fluoxetine order was left as a pending order. Staff did not know there was a dose increase because of this and R8 did not receive any of the medication for 6 days. R8's 11/21/23 physician order showed to give fluoxetine (an antidepressant medication) 60 milligrams (mg) daily. R8's 8/22/24 physician order showed a dose increase of the fluoxetine to 80 mg daily. This order showed the medication was ordered for major depressive disorder and schizoaffective disorder, bipolar type. R8's August 2024 medication administration record (MAR) showed no fluoxetine was administered on 8/25-8/30/24 (6 days). R8's 8/30/24 at 12:19 PM general note showed she stated to multiple people she does not want to live like this anymore. R8's 8/30/24 at 1:16 PM general note showed she was transported to a local hospital for a psychiatric evaluation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R8's 8/31/24 2:26 AM general note showed she was evaluated in the emergency room due to verbalizing she wanted to commit suicide with no plan. R8's care plan showed she had a history of depression and to administer medications as ordered. R8's care plan showed she refuses to wear a brief for incontinence and states that the incontinence makes her feel suicidal at times but has no plan to self-harm. 39537 2. R21's Facesheet dated 9/4/24 showed diagnoses to include, but not limited to: diabetes, Crohn's Disease, COPD (chronic obstructive pulmonary disease), hypertension, major depressive disorder, mild cognitive impairment, and generalize muscle weakness. On 9/4/24 at 8:38 AM, V3 (LPN - Licensed Practical Nurse) prepared medications for R21. V3 placed R21's lisinopril (blood pressure medication) in a separate medication cup. V3 stated, I always check the vital signs before I give the blood pressure medications. I don't see any (blood pressure) parameters on the lisinopril, but I know the doctor and they wouldn't want me to give it if the BP is low. V3 gathered the automatic, wrist BP cuff; R21's medications; and the glucometer supplies. V3 obtained R21's BP and it was 99/56. V3 told R21, I'm not going to give you the lisinopril your blood pressure is too low. V3 did not performed any further assessment on R21. V3 left R21's room and disposed of the lisinopril. V3 documented the reason R21's lisinopril was held was low BP. R21 did not call the doctor, assess the resident for any changes in condition, or re-check his BP later in the day. R21's September 2024 MAR (Medication Administration Record) showed an order for lisinopril 10 mg tablet by mouth once a day for HTN (hypertension). This order does not contain parameters for blood pressure and medication administration. On 9/4/23 chart code 9 was entered by V3 (LPN). This documented showed that 9 means other, see progress notes. R21's Weights and Vitals Summary dated 9/5/24 showed on 9/3/24 at 8:24 AM, R21's BP was 92/64. This reading was the lowest BP on this report since 10/19/23. There was no blood pressure documented on 9/4/24 (when V3 held the lisinopril). (The blood pressure readings on 9/3/24 and 9/4/24 were both lower than R21's usual blood pressure readings, this trend should have been assessed and monitored by nurse). R21's Progress Notes were reviewed. There were no notes regarding R21's low blood pressure, V3 holding R21's lisinopril, notification of the doctor, or follow-up assessments. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/5/24 at 9:05 AM, V2 (DON - Director of Nursing) said lisinopril is a medication for hypertension. V3 said if the doctor wants a medication held, then he would set the vital sign parameters. V2 said if there weren't any blood pressure parameters, then she would re-check the BP and perform an assessment of the resident. The surveyor informed V2 that R21's systolic blood pressure average in the 130-140 range. V2 replied, Well that would be a change. They should do an assessment, re-check the BP, and continue to monitor. The vital signs should be charted and any follow-up assessments. If the nurse held lisinopril, then she should let the doctor know. He needs to know if the medications aren't given, there may need to be some medication changes made. At 11:30 AM, V2 said she reviewed R21's chart and V3 had not re-checked R21's blood pressure, performed an assessment, or called the doctor. V2 said there isn't a progress note because it wasn't done. V2 stated, I'll be talking to [V3 - LPN], she should have follow-up with that. On 9/5/24 at 11:45 AM, the surveyor asked V3 if she had notified the doctor that she held the lisinopril. V3 replied curtly, Why would I call the doctor for holding that medication? I didn't call the doctor, but I have the numbers in my phone. V3 said she that blood pressure was a little low for R21, but she didn't call the doctor, assess R21, or re-check his blood pressure later in the day (9//24). V3 stated, I just held the medications because I know what the doctor would say. The surveyor asked how a doctor would know if there was a need to changed medications or medication dosages and V3 stared at me blankly and replied, Well I don't know. There won't be any documentation there because I didn't do any. I guess I should have. The facility's Medication Administration Policy dated 11/18/17 showed, Drugs and biologicals are administered by physicians and licensed nursing personnel . 22. Notify the physician as soon as practical when a scheduled dose of a medication has not been administered .

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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** 20042 Based on observation, interview, and record review, the facility failed to ensure a resident with dysphagia and orders for a pureed diet was supervised and sitting upright when eating. This failure affects 1 of 1 resident (R17) reviewed for safety and supervision in the sample of 12. Findings include: On 9/3/24 at 12:50 PM, R17 was laying in bed with the head of her bed at 45 degrees. R17 was alone in her room feeding herself a pureed diet. R17 stated her bed should be up higher but that it was too late now because she was already eating. R17 stated she was on a pureed diet because she would choke on the diet she had before. On 9/3/24 at 12:57 PM, V6 CNA (Certified Nursing Assistant) and V5 CNA were out in the hall doing other tasks. V5 and V6 were asked why R17 was sitting with the head of her bed at 45 degrees while trying to feed herself a pureed diet. V5 stated R17 wasn't supposed to be. V6 asked V5 who gave R17 her tray. V5 went into R17's room, cranked R17's head of the bed up and stated R17 was supposed to be sitting up at 90 degrees when eating her food so it goes down and she doesn't choke. On 9/4/24 at 10:48 AM, V7 (Dietary Manager) stated, R17 has worked with therapy a few times. I know she would eat too fast and start coughing and choking so therapy worked with her a few times. I will look for the paperwork. R17 assists herself. R17 should be sitting upright in her chair to make sure she has the ability to swallow without any issues. That should be in her care plan. V7 stated R17 should not be sitting in her bed with the head of her bed at 45 degrees while eating because it is a choking hazard. V7 stated she did not have a speech therapy evaluation for R17. V7 stated they had problems with therapy for awhile at the facility. V7 stated if a resident had speech therapy the information would be given directly to V2 DON (Director of Nursing). On 9/4/24 at 11:07 AM, V2 DON (Director of Nursing) stated R17 had a stroke and is on a pureed diet. R17 shouldn't even be in her room eating for one, it's for aspiration. R17 should be sitting upright to eat to keep her from aspirating. The Dietary assessment dated [DATE] for R17 showed, pureed diet; swallowing problems - dysphagia; and adaptive devices used/needed - divided plate. The Care Plan dated 6/5/24 for R17 showed, nutritional status: puree. Resident enjoys a soda with lunch. Determine residents ability to chew and swallow. Document and monitor weekly/monthly weights. Educate resident/representative regarding nutritional needs. Modify diet as appropriate according to residents food tolerances and preferences. Offer a divided plate for all meals. Offer puree diet for all meals. R17's Care Plan did not show any swallowing precautions or positioning needs for eating. The MDS (Minimum Data Set) assessment dated [DATE] for R17 showed she needs supervision or touching assistance with eating. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Face Sheet dated 9/4/24 for R17 showed diagnoses including dysphagia, chronic obstructive pulmonary disease, type 2 diabetes mellitus, left side hemiparesis, hypertension, muscle weakness, gastro-esophageal reflux disease, hypothyroidism, major depressive disorder, hypomagnesemia, unsteadiness on feet, cerebral infarction, need for assistance with personal care, hyperlipidemia, insomnia, and left hand contracture. The Physician Orders dated 9/4/24 for R17 showed, controlled carbohydrate diet, pureed texture, regular/thin consistency. Swallowing precaution: pockets food. On 9/4/25 at 2:00 PM, V2 DON (Director of Nursing) presented the requested documents for R17 and the facility did not have a speech therapy evaluation for R17. The facility's Swallow Evaluation & Swallow Guidelines policy (10/2013) showed, Procedure: 1. If a resident has a diagnosis of dysphagia on admission, then nursing shall obtain a copy of a prior swallow evaluation to retain in the active medical record. 2. If a swallow evaluation was not done previously or is unavailable the nursing shall contact therapy and request a swallow screen and retain the report of the swallow screen in the active medical record. Following evaluation by Speech Therapy, nursing will notify the Food Service Department in writing of any swallow guidelines, swallow precautions, or aspiration precautions. 3. Upon receipt of the written guidelines from speech therapy, the Food Service Manager or designee will generate a Precautions for Feeding & Swallowing tray card. 8. Swallow guidelines, swallow precautions, or aspiration precautions shall be addressed on the resident's care plan. The facility's Therapeutic & Mechanically Altered Diets policy (10/2020) showed, a mechanically altered diet is a diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, and ground meat. The policy did not include any swallowing precautions/aspiration precautions.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 20042 Based on observation, interview, and record review the facility failed to ensure a resident's tube feeding was stopped when the head of her bed was flat during care. The facility failed to ensure a feeding tube site care was done as needed and a dressing was in place for 2 of 2 residents (R11, R14) reviewed for tube feeding in the sample of 12. Findings include: 1. On 9/3/24 at 9:36 AM, R11 had tube feeding infusing at 60 ml (milliliters) per hour. V4 (Respiratory Therapist) and V3 LPN (Licensed Practical Nurse) were at R11's bedside for education related to her trach (tracheostomy) and to change R11's trach. V4 stated the head of the bed needed to be flat and pillows removed when the trach is changed. V3 lowered the head of the bed flat and removed the pillow under R11's head. V3 did not stop or pause R11's tube feeding. V4 and V3 had gloves on and were at R11's bedside. V4 instructed V3 on how to remove the trach ties. They were unable to get the ties undone and had to cut the trach ties. V3 placed two fingers on either side of the trach to keep it in place. V4 grabbed the new uncuffed number 6 trach with obturator from the container on the bed and put lubricant on the trach. V4 told V3 on the count of three, V3 would pull the old trach out and V4 would immediately place the new one. V3 and V4 counted to three and V3 pulled out R11's old trach. V4 placed the new trach and removed the obturator. V4 and V3 put the trach ties on the trach to secure it in place. V3 raised the head of R11's bed to 45 degrees. R11's tube feeding continued to infuse at 60 ml per hour. At 10:05 AM, V5 CNA (Certified Nursing Assistant) and V6 CNA came into R11's room to provide incontinence care. V6 stated R11's tube feeding was running so she would get V3 LPN to come in and shut it off. At 10:07 AM, V3 came into R11's room and shut the tube feeding off. On 9/4/24 at 10:55 AM, V3 LPN (Licensed Practical Nurse) stated a resident's tube feeding is paused for care and whenever the residents head is not elevated. V3 stated this is done as an aspiration precaution. On 9/14/24 at 11:07 AM, V2 DON (Director of Nursing) stated, tube feeding should be held with orders. R11's tube feeding is to be stopped for 4 hours per day. The only time we would pause it would be for care for her like a shower or to change her linens. They have to lay R11 flat, so they have to put the tube feeding on hold so she doesn't aspirate. V2 stated R11 can't have tube feeding running while lying flat. The Face Sheet dated 9/4/24 for R11 showed medical diagnoses including anoxic brain damage, chronic respiratory failure, tracheostomy, dysphagia, colostomy, autistic disorder, anemia, epilepsy, contracture, and cerebral palsy. The Physician Orders dated 9/4/24 for R11 showed, enteral feed every shift for supplement. Diabetic tube feeding 1.2 at 60 ml per hour x 20 hours then off for 4 hours. The physician orders did not state to keep head of be elevated while tube feeding is infusing. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 8/15/24 for R11 showed, Nutritional status - NPO (nothing by mouth). All nutrition given through feeding tube. Document and monitor weekly/monthly weights. Educate resident / representative regarding nutritional needs and requirements. Flush feeding tube with 200 ml of water every 6 hours. Flush feeding tube with 30 ml of water before and after administration of medication, rinse syringe and place in plastic bag for storage. Modify diet as appropriate according to resident's food tolerances and preferences. Diabetic tube feeding 1.2 @ 55ml per hour x 20 hours then off for 4 hours. The care plan did not show at what level the head of her bed should be when tube feeding is infusing and/or if it should be stopped/paused when the head of the bed is flat. The facility's Tube Fed Residents policy (10/2013) did not show that the head of the bed should be elevate while tube feeding is infusing and pause or stopped when the head of the bed is flat. The facility's Enteral Feeding - Closed System - Ready to Hang Product (2/2008) showed, Procedure: place resident with the head of the bed elevated to a 30-40 degree angle. 2. On 9/4/24 at 1:35 PM, R14 was in bed on his back with the head of his bed levated 30 degrees. R14 had tube feeding infusing at 80 ml per hour. R14 stated that his feeding tube dressing doesn't get changed every day. On 9/4/24 at 1:40 PM, V5 CNA (Certified Nursing Assistant) went into R14's room with the surveyor. V5 pulled back R14's blanket and R14 did not have a dressing in place at his feeding tube site. There was serous fluid present at the feeding tube site and redness and a dried, caked, reddish brown substance to R14's skin near the opening in his skin for the enteral feeding tube. On 9/4/24 at 1:47 PM, V2 DON (Director of Nursing) went to R14's bedside with the surveyor to check his feeding tube site. V2 stated there was serous drainage present and the area was not clean. V2 stated there was a reddish caked substance on his skin and the area looked like it had not been cleaned. V2 stated the area looked reddened. V2 stated R14 needed his feeding tube site cleaned and was supposed to have a dressing in place. On 9/4/24 at 1:52 PM, V3 LPN (Licensed Practical Nurse) stated R14 doesn't have a dressing to his feeding tube site. V3 stated she hasn't cleaned R14's feeding tube site. V3 stated there is a reminder for them in his medical record to do it sometime between 6 AM - 6 PM. The Face Sheet dated 9/4/24 for R14 showed diagnoses including multiple sclerosis, gastrostomy, lack of coordination, hyperkalemia, muscle weakness, gastro-esophageal reflux disease, hypothyroidism, sepsis, pneumonitis, and major depressive disorder. The Physician Orders dated 9/4/24 for R14 showed, cleanse g-tube site with normal saline and apply split gauze daily. The MAR (Medication Administration Record) dated September 2024 for R14 showed, cleanse g-tube site with normal saline and apply a split guaze daily in the afternoon for wound. The Care Plan dated 7/4/24 for R14 showed, Nutritional status NPO (nothing by mouth), receives all nutrition through g-tube (enteral feeding tube). Resident g-tube will remain free of s/s of irritation through next review. Cleanse g-tube site with normal saline and apply split gauze daily.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on observation, interview, and record review the facility failed to ensure a smaller sized tracheostomy tube was at a residents bedside, respiratory care equipment was changed weekly, and oxygen saturations were being monitored for a resident on as needed oxygen for 2 of 2 residents (R11, R6) reviewed for tracheostomy/respiratory care in the sample of 12. Findings include: 1. On 9/3/24 at 9:36 AM, V4 (Respiratory Therapist) and V3 LPN (Licensed Practical Nurse) were at R11's bedside for education related to her trach (tracheostomy) and to change R11's trach. V4 stated the head of the bed needed to be flat and pillows removed when the trach is changed. V3 lowered the head of the bed flat and removed the pillow under R11's head. V4 and V3 had gloves on and were at R11's bedside. V4 instructed V3 on how to remove the trach ties. They were unable to get the ties undone and had to cut the trach ties. V3 placed two fingers on either side of the trach to keep it in place. V4 grabbed the new uncuffed number 6 trach with obturator from the container on the bed and put lubricant on the trach. V4 told V3 on the count of three, V3 would pull the old trach out and V4 would immediately place the new one. V3 and V4 counted to three and V3 pulled out R11's old trach. V4 placed the new trach and removed the obturator. V4 and V3 put the trach ties on the trach to secure it in place. V4 stated there should be a smaller trach at bedside in case R11's trach comes out. V4 stated R11 should have a size 4 of the same trach at her bedside. V4 stated a size 6 trach would probably not go back in if the trach came out because the airway would be smaller. V4 looked for a size 4 trach in R11's supplies in the room and could not find it. V4 stated there were two size 6 tracheostomies at bedside but there should be a size 4 trach at bedside. V3 looked in R11's supplies and could not find the size 4 trach. On 9/4/24 at 11:07 AM, V2 DON (Director of Nursing) stated there should be and extra trach kept nearby in R11's room. V2 stated, there should be a trach that is the same size as R11's trach and one that is a size smaller. V2 stated it was important to have a smaller trach at bedside because if there was swelling at the trach site the smaller one would go in easier. The Face Sheet dated 9/4/24 for R11 showed medical diagnoses including anoxic brain damage, chronic respiratory failure, tracheostomy, dysphagia, colostomy, autistic disorder, anemia, epilepsy, contracture, and cerebral palsy. The Physician Orders dated 9/4/24 for R11 showed, Tracheostomy - suction tracheostomy to maintain O2 (oxygen) saturation when coughing or excess secretions noted. Site care - remove dressing from under flange, cleanse outer cannula and skin daily with normal saline and gauze. Cleanse under cannula with cotton applicator and replace dressing under the flange. Treatment site: tracheostomy. Direction: tracheostomy - respiratory therapy to change monthly. Treatment site: trach inner cannula. Direction: #6 (trach tube size) change daily and as needed. There wasn't an order for a smaller size trach to be at bedside. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 8/15/24 for R11 showed, the resident has a tracheostomy related to impaired breathing mechanics. Ensure that trach ties are secured at all times. Monitor/document for restlessness, agitation, confusion, increased heart rate (tachycardia), and bradycardia. Monitor/document level of consciousness, mental status, and lethargy PRN (as needed). Monitor/document respiratory rate, depth and quality. Check and document every shift/as ordered. Provide good oral care daily and PRN. Reassure resident to decrease anxiety. Suction as necessary. The Care Plan did not show the size or type of tracheostomy, what to do in an emergency, or that a smaller tracheostomy should be at the bedside. The TAR (Treatment Administration Record) dated September 2024 For R11 showed the trach inner cannula is to be changed daily and as needed. Trach: Site care - Remove dressing from under flange, cleanse outer cannula and skin daily with normal saline and gauze. Cleanse under cannula with cotton applicator and replace dressing under the flange. Treatment site: trach dressing. Direction: change every shift. Trach: may suction tracheostomy to maintain O2 (oxygen) saturation, when coughing or excess secretions noted, as needed every shift. The TAR did not show that a smaller trach was at R11's bedside. The facility's Tracheotomy Care policy (3/29/2019) showed, A replacement tracheostomy tube is to be kept at the head of the bed at all times, clearly visible. The policy did not state that the resident's current size and a smaller size tracheostomy tube should be at bedside. 35175 2. R6's face sheet showed a [AGE] year old female with diagnosis of chronic obstructive pulmonary disease, morbid obesity, anxiety disorder, schizoaffective disorder, bipolar type, major depressive disorder, hypertension, pseudobulbar affect, moderate intellectual disabilities, dementia, and Parkinson's disease. On 09/03/24 at 09:49 AM, R6 was in bed. R6 had a nasal cannula in both nostrils. The tubing was dated 8/11/24. The oxygen humidifier bottle was dated 8/3/24. R6's oxygen was on at 2 liters via an oxygen concentrator. At 12:55 AM, R6 was in the dining room without oxygen on. There were indentations on both cheeks from the tubing. On 09/04/24 at 11:38 AM, V3 Registered Nurse (RN) said R6 has oxygen on at night. I haven't done oxygen saturations on her. V3 said nothing has popped up on the computer to alert her to do it. At 11:43 AM, V5 Certified Nursing Assistant (CNA) said R6 wears oxygen at night. When we come on in the morning, the oxygen is on her. I've been here since April and that's her routine. We take the oxygen off when we get her up. At 11:50 AM, V6 CNA said R6 always has oxygen on in the morning. We take it off when we get her out of bed. She lays down for a nap every day and we put the oxygen on her for her nap. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/04/24 at 12:52 PM, V2 Director of Nursing (DON) oxygen humidifier bottles and nasal cannulas should be changed weekly. It is important it gets done to ensure the integrity of the equipment and to prevent infections. I would expect oxygen saturations are checked if oxygen is ordered as needed (prn). CNAs are not supposed to apply oxygen. It's considered a medication and they are not licensed to administer oxygen. R6's physician order sheet showed a 4/10/23 order for oxygen at 2 liters (L) via nasal cannula to maintain sats at 90%. R6's treatment administration record (TAR) showed oxygen was not used in August or September 2024. R6's oxygen saturation record showed no readings for September 2024 and the last date recorded was 8/4/24. R6's care plan showed no plan of care for oxygen use. The facility's 3/19 Oxygen Therapy Policy showed oxygen is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress. Oxygen therapy may be used provided there is a written order by the physician. Change oxygen tubing/mask/cannula/or tracheostomy mask on a weekly basis. Date tubing changes and document on the treatment sheet. If humidification is indicated, date prefilled bottles.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39537 Based on observation, interview, and record review the facility failed to ensure there was a RN (Registered Nurse) working 8 consecutive hours, 7 days week. This effects all residents residing in the facility. Findings include: The facility's CMS 671 Form dated 9/3/24 showed 21 residents resided in the facility. The CMS PBJ Staffing Data Report for Quarter 2 (January 1 - March 31) showed the facility triggered for no RN hours. On 9/5/24 at 9:22 AM, V2 (DON - Director of Nursing) said she covers some open shifts and call offs. V2 said she is supposed to work days, but was working a lot of nights from 1/1/24-3/31/24. V2 said she is salaried staff and is only required to punch in. V2 said she gets her hours in. V2 said most days should have 8 hours of RN coverage, but there may be some weekends there wasn't an RN. The facility provided the monthly working schedule, timecards for the nurses, and a lengthy Labor Detail Report. There were several conflicts noted between the nurses listed on the schedules and the timecards and/or the Labor Detail Report. On 9/5/24 at 10:38 AM, the surveyor sat down with V15 (BOM - Business Office Manager) to review provided documents. V15 stated, I'm sorry it's so confusing. V15 said the Labor Detail Report is lengthy because it includes all the staff working each day from 1/1/24 to 3/31/24. V15 said she provided timecards with signatures for the agency staff and punch detail reports of the facility staff. V15 said she is the on-site payroll person. V15 said she reviews the punches, but the payroll system isn't very reliable. Upon reviewing the documents with V15 it was determined that there was not 8 hours of consecutive RN coverage on 1/27/24, 2/26/24, 3/9/24, 3/10/24, 3/16/24, 3/17/24, and 3/31/24 (6 of the 7 days were weekends).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review, the facility failed to have an adequate supply of medication for administration for 1 of 1 resident (R14) reviewed for medication administration in the sample of 12. Findings include: R14's face sheet showed a [AGE] year old male with diagnosis of multiple sclerosis, gastrostomy status, severe sepsis and major depressive disorder. On 09/03/24 at 03:28 PM, V3 Licensed Practical Nurse (LPN) was preparing medications to administer to R14. R14's lactulose concentrate 10 gram (gm) per 15 milliliter (ml) order was for a 60 milliliter dose. V3 poured 10 ml from his bottle and it was empty. V3 looked in the medication cart and there was not another bottle. V3 said she'd have to order more. V3 then took R10's open bottle of lactulose and added the additional 50 ml to the medication cup for administration. V3 verbally verified she was using R10's medication for R14's dose. V3 proceeded to administer the medication to R14 via his gastric tube and documented the dose was administered. On 09/04/24 at 12:58 PM, V2 Director of Nursing (DON) said borrowing medication from another resident is not acceptable practice. The cost comes out of their insurance, it is not safe and does not follow the five rights of medication administration. R14's physician order sheet (POS) showed to give lactulose 10 gm/15 ml, 60 ml two times a day. R10's POS showed an order for lactulose 10 gm/15 ml two times a day. R14's September 2024 medication administration record (MAR) showed V3 gave R14 60 ml of lactulose on 9/3/24 at 4:00 PM.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 35175 Based on observation, interview, and record review, the facility failed to store medication in a manner to maintain safety and control of the medication supply. This failure has the potential to affect all 21 facility residents. Findings include: The facility form 671 dated [DATE] showed 21 residents in the facility. On [DATE] at 08:53 AM, during the medication storage task, the facility's one medication cart showed two cephalexin (antibiotic) 500 milligram (mg) capsules in packaging lying in the bottom of a drawer. There were no resident or pharmacy identifiers on the medication. Another drawer had a bottle of eye drops with R11's name on it and an opened date of [DATE]. On [DATE] at 09:18 AM, V3 Licensed Practical Nurse (LPN) said the night shift checks refrigerator temps. V3 said she does not know where the temperature log was. V3 read the temperature of the thermometer in the medication refrigerator as 44 degrees. The refrigerator contained two bottles of morphine labeled for R14 and R7. The open freezer section had ice over the shelf edge approximately two inches thick. There were popsicles on top of the ice and were melted. There were stock tubersol, stock insulin, suppositories, and injectable medications. A binder labeled night shift was at the nurses station directly in front of the medication room door. There was a white paper dated [DATE] on front of the binder that read temps on the medications need to be done two times per day. It is a state requirement because there is flu and pneumonia in the fridge. The notice was signed by V2 Director of Nursing (DON). The last time the medication refrigerator temperatur log was completed was [DATE]. There were no complete logs for any month back to [DATE]. At 9:40 AM, V2 DON said it's important the refrigerator temperature is checked twice a day to make sure they're not frozen as that would damage the medication. If the temperature is too high it could alter the medications efficacy. We are going to fix this tonight. It has been a problem in the past and that's why her note is on front of the binder. I should have been checking it to make sure it was done and I haven't been checking it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's [DATE] Procurement and Storage of Medications Policy showed all medication brought into the facility shall be labeled with at least the following information: name, address and phone number of dispensing pharmacy, resident name, physician name, name and strength of medication, directions for administering, last date dispensed and prescription number; both the brand and generic name if substitution is made and appropriate auxillary labeling. All discontinued/expired non-controlled medications are to be removed from the active medication storage area. All medication should then be returned to pharmacy or destroyed. The facility provided medication storage guidance showed to date eye drops when opened and discard after 28 days. Morphine sulfate concentrate oral solution should be stored at ,d+[DATE] degrees Fahrenheit and excursions of ,d+[DATE] degrees are permitted by certain manufacturers. Safe and secure storage means abiding by proper temperature controls as well as maintaining appropriate light and humidity exposure.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record the review the facility failed to ensure dietary staff completed the food safety training. This affects all residents residing in the building. Findings include: The facility's CMS 671 form dated [DATE] showed there were 21 residents residing in the facility. On [DATE] at 9:13 AM, V7 (Dietary Manager) said V8 and V9 were trained to cook and perform dietary aide duties. V7 said they alternated between the roles, but today V8 is the cook and V9 is working the dietary aide role. On [DATE] at 11:01 AM, V7 (Dietary Manger) said she had completed food safety and dietary manager's training. V7 said the certificates were in her office. V7 said V8 (Cook/Dietary Aide) is new and hasn't finished her training yet. V7 said V9 (Cook/Dietary Aide) had worked at the facility before, left for a while, and had been back a couple years. V7 stated, I'll have to see if her (V8's) training expired. The surveyor requested copies of V7, V8, and V9's certifications. At 1:24 PM, V7 (Dietary Manager) had not provided copies of the requested certificates. The surveyor went to the kitchen and met V8 (Cook/Dietary Aide) near doorway. V8 stated, I've been at the facility ,d+[DATE] months. I had Food Handler training before, but it expired. I told them (the facility) in my interview that my certification had expired. Usually my employers sets up the training, but they haven't done that here. V9 (Cook/Dietary Aide) said she had been working at the facility a couple years and her Food Handler had expired. The surveyor asked V7 (Dietary Manager) if the facility assists the dietary staff with training arrangements. V7 replied, We have to keep our training up-to-date ourselves. They don't pay us to do training. The purpose of the food safety training is to understand the cooking regulations and safe food handling. They (the facility) wants us to do all the training online now. On [DATE] at 1:41 PM, V1 (Administrator) said she expects the dietary staff to have food handler training and keep it up to date. V1 stated, [The food service contractor] has a website and the training can be completed online. It's just a matter of them being given the time to completed it. It is the Dietary Manager's responsibility to set up her staff training and ensure the appropriate certifications are completed. The facility's [NAME] Job Description revised ,d+[DATE] showed, Job Summary: Prepares and serves nutritious meals according to the menu. Monitors methods of food handling, preparation, meal service, and equipment cleaning. Ensures all health, safety and environmental health standards are achieved and maintained. Qualifications: . 8. Must have passed the sanitation test or be willing to take the course approved by the state the facility is in. 9. Must receive food handler training within 30 days of employment . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Dietary Aide Job Description revised ,d+[DATE] showed, Job Summary: Provides nutritious meals according to the menu. Ensures the sanitation of the kitchen food preparation and tray line area. Qualifications: .8. Must have passed the sanitation test or be willing to take the course approved by the state the facility is in. 9. Must receive food handler training within 30 days of employment .

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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. 39537 Based on observation, interview, and record review the facility failed to ensure the dishes were properly sanitized; failed to use the 3 compartment sink properly; and failed to prevent chemical contamination of pureed food. This affects all residents residing in the facility. The findings include: The facility's CMS 671 Form dated 9/3/24 showed 21 residents resided in the facility. 1. On 9/3/24 at 9:13 AM, V7 (Dietary Manager) accompanied the surveyor on a kitchen tour. The 3 compartment sink was empty. The surveyor asked if the dietary staff used the 3 compartment sink and she replied, We don't really use that. We run everything through the dishwasher. On 9/3/24 at 9:25 AM, V9 (Cook/Dietary Aide) was standing at the dishwasher. V9 said she had already finished most of the breakfast dishes, but had a couple trays left. V9 removed the tray that was inside the dishwasher and pushed the last tray of dirty dishes into the dishwasher and started the dishwashing cycle. V9 walked away and obtained chlorine testing strips. The surveyor asked V9 when she checks the dishwasher to ensure it is working properly. V9 replied, I test the temp at every meal to ensure it's reaching temperature (V9 was using chlorine testing strips). After the dishwasher ran through a cycle. V9 tested the water that was exiting the machine in a small, collection drain on the exterior of the dishwasher, near the lower right corner. There were 3 hoses running down the front of the machine, with the end resting just above the collection drain. The hoses fed 3 solutions: rinse aid, sanitizer, or detergent into the dishwasher from the jugs of chemicals that were on the floor. V9's test strip turned a light gray color, demonstrating the chlorine level was between 10-25 PPM (parts per million). The surveyor asked V9 what that result means. V9 stated, It's not temping right. I know the temp is supposed to be like 120 degrees before I do the test strip. V7 (Dietary Manager) walked over and told V9, Remember you have to make sure the temperature reaches 135 before you try to test the sanitizer. It can take a little while for the dishwasher to reach temp in the mornings. The temperature dial, near the collection drain, showed 120 degrees when the dish cycle was running. V7 said we'll have to run the dishwasher through a few cycles to warm it up. The dishwasher was run through four cycles and the temperature increased slightly, but did not reach 135. V9 (Cook/Dietary Aide) dip a test strip in the water, inside the dishwasher. The test strip turned light gray. V9 started the dishwasher again, while V7 (Dietary Manager) checked the containers of chemicals, under the dishwasher. V7 said the chemicals should be automatically fed into the dishwasher, through these hoses. V9 (Cook/Dietary Aide) stated, I changed over the chemicals a couple days ago. V7 said, Let's try one more cycle. If it doesn't work I will have to contact [the service company]. V9 tested the water in the collection drain and the test strip turned light gray again (between 10-25 PPM of chlorine). V7 (Dietary Manager) said the chlorine level should be 50-100 PPM to properly sanitize the dishes. V7 flipped the prime switch near each chemical. Liquid dripped from the rinse aide and detergent lines, but not the chlorine line. V7 stated, For some reason the sanitizer isn't coming out. This happened a few weeks ago and they had to change the hose in the back of the machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Ware-washing - Dishwashing Policy dated 10/09 showed, It is the policy of [the corporation] that utensils and dishes washed by mechanical dishwasher will be clean and sanitized. Procedure: .3. For Low Temperature Dishmachines (temperature of wash water shall not be less than 120 degrees Fahrenheit) - Before washing anything, use a test strip to check the sanitizer level. a. For Chlorine sanitizers, the level should be 50-100 PPM . 2. On 9/3/24 at 11:29 AM, V9 (Cook/Dietary Aide) was attempting to set up the 3 compartment sink. V9 said the dishwasher is still out of order, so I'm getting this ready to go. The first compartment had warm, soapy water; the 2nd compartment was empty with the hose available to rinse; and the 3rd compartment had a low water level (approximately 1/4 of the way full. V9 obtained the QAT sanitizer testing strips. V9 dipped the test strip into the water and it turned a deep turquoise color. The color was beyond the 500 PPM results range, shown on the testing strip container. V7 (Dietary Manager) approached and told V9 to add water because the QAT test should be 300. To the right of the 3rd compartment (for sanitizing) there was not a drying area. There was a small handwashing station, then the wall. On 9/3/24 at 11:34 AM, V8 (Cook/Dietary Aide) said she was ready to start the pureed diets. V8 had pureed menu cards for R1, R6 and R17 in front of her. V8 pureed the barbecue chicken breasts and placed 3 portions into divided plates. At 11:41 AM, V8 removed the robo coupe container from the base and approached the 3 compartment sink. V8 washed and rinsed the robo coupe container. V8 dipped the robo coupe container into the sanitizing sink and immediately removed it. The container was dripping sanitizing fluid across the kitchen floor. V8 placed the blending container on to the base. There was sanitizing liquid visible inside the blending container. (The container was not submerged for 30 seconds in the sanitizing sink and it was not air dried). V8 pureed the carrots. When she removed the robo coupe container from the base, the sanitizing liquid was dripping from the bottom of the container into the divider plates with the pureed chicken. V8 returned to the three compartment sink again and failed to submerge the container for 30 seconds in the sanitizing sink and did not allow the container to air dry. At 11:45 AM, she pureed the bread slices. V8 removed the robo coupe container from the base and the sanitizing liquid was dripping. As she portioned each serving into a shallow dish, the sanitizer dripped onto the pureed chicken and cream corn, already prepared in the divider plates. At 11:58 AM, V8 continued the same process to puree the cream corn. Again the sanitizing liquid dripped from the robo coupe container, into R1, R6, and R17's pureed foods. On 9/4/24 at 11:01 AM, V7 (Dietary Manager) said each bay of the 3 compartment sink is assigned. One for washing with soap, a rinse bay in the center, and one for sanitizer at the end. The QAT sanitizer automatically feeds into the sink, but we have to test it to make sure it's at the proper level. V7 said the blender should be washed, rinsed, submerged in the sanitizer sink for 30 seconds, and air dried. V8 said this is done to ensure the items are clean, free of food debris, and sanitized. V7 said the item should be air dried. The surveyor described the sanitizing liquid dripping into the resident's pureed plates/food. V7 replied, That shouldn't be happening. V7 said it could be unsafe for the resident's to ingest the sanitizing liquid. The facility list of pureed residents showed R1, R6 and R17. The Safety Data Sheet for Quaternary Sanitizer (QAT) showed ingestion may cause nausea. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's 3 Compartment Sink Policy revised 10/17 showed, It is the policy of [the corporation] that utensils and dishes that cannot be cleaned and sanitized by a mechanical dishwasher will be cleaned and sanitized in a 3-compartment sink. Procedure: . 7. For Chemical Sanitizing - Before sanitizing anything, use a test strip to check the sanitizer level in the third sink b. For QAT sanitizers, the level should be 200 . 9. Items must be immersed for at least 30 seconds in the third (sanitizing) sink. 10. Air dry all items. Avoid touching food contact surfaces .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39537 Based on observation, interview, and record review the facility failed to ensure the glucometer was cleaned in a manner to prevent cross-contamination (R14, R17, R12, R4, R8, R21); failed to properly perform hand hygiene (R14); failed to position a R14's G-tube in a manner to prevent cross-contamination (R14); failed to wear a gown during close contact with a resident in EBP (Enhanced Barrier Precaution) isolation (R11); and failed to change gloves in manner to prevent cross-contamination (R1) for 8 of 8 residents (R14, R17, R12, R4, R8, R21, R11, R1) reviewed for infection control in the sample of 12. Findings include: 1. On 9/4/24 at 8:38 AM, V3 (LPN - Licensed Practical Nurse) was preparing medications and the glucometer supplies for R21. V3 had two glucometers, stacked on top of each other, on the right side of the medication cart, loosely wrapped in a white wipe. V3 removed the top glucometer, turned it on, and inserted a test strip. V3 opened an alcohol wipe and set it directly on top of the glucometer, along with a single use lancet. V3 collected the medications and supplies and entered R21's room. V3 handed R21 his inhaler and set the glucometer down on R21's bedside table. V3 explained that she needed to check R21's blood sugar and he held out his finger. V3 used the opened, alcholol wipe, from the meter, to cleanse his finger and obtained a blood sample. V3 told R21 his blood sugar results and said she needed to go prepare his insulin. V3 took the glucometer out of the room and set it on the left side of the medication cart. V3 did not wipe the glucometer with a bleach wipe before placing it on the medication cart. V3 prepared R21's insulin, returned to his room to administer it, and left the glucometer on the left side of the cart. R21's Facesheet dated 9/4/24 showed diagnoses to include, but not limited to: diabetes, Crohn's Disease, COPD (chronic obstructive pulmonary disease), hypertension, major depressive disorder, mild cognitive impairment, and generalize muscle weakness. R21's September 2024 MAR (Medication Administration Record) showed his blood sugar was checked twice a day (8:00 AM and 8:00 PM). On 9/4/24 at 8:48 AM, V3 (LPN) prepared R14's Gastrostomy tube (Gtube) medications, removed the glucometer from the loosely wrapped (V3 did not wipe the glucometer prior to removing it), white wipe, and placed the contaminated glucometer (used to test R21) into the same white wipe. V3 did not use any friction to clean the glucometer, nor did she obtain a new wipe to cleanse the glucometer. R14 had an EBP sign on his door. V3 opened an alcohol wipe package and placed it directly on the glucometer. V3 entered R14's room with the Gtube medications and glucometer testing supplies. V3 set the glucometer R14's bedside table with an empty urinal, a tube of incontience cream, a box of kleenex, and a container of cleansing soap. V3 used the opened, alcohol wipe to cleanse his finger and obtained a blood sample. V3 placed the glucometer back onto R14's bedside table and administered the G-tube medications. V3 picked up the glucometer with her bare hands and returned to the medication cart. V3 placed the contaminated glucometer on the top left side of the medication. V3 did not clean the glucometer with a new bleach wipe. The contaminated glucometer remained on the left side of the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R14's Facesheet dated 9/4/24 showed he had diagnoses to include, but not limited to: multiple sclerosis, gastrostomy tube (G-tube), lack of coordination, generalized muscle weakness, hypothyroidism, GERD (gastro-esophageal reflux disease), and major depression. R14's September 2024 MAR showed he had blood glucose tests twice day (7:00 AM and 4:00 PM). On 9/4/24 at 10:30 AM, V2 (DON - Director of Nursing) was asked what the facility used to clean the glucometers. V2 obtained the medication cart keys from V3 and provided the surveyor with a bleach wipe. The instructions on the back of the bleach wipe packet showed, Tear open packet. Unfold wipe and use as directed. Discard after single use. On 9/5/24 at 8:58 AM V2 (DON) said the facility had 2 glucometers in use and one back up. V2 said the glucometers should be on the medication cart and were shared for the residents that needed their blood sugars checked. V2 said the glucometer should be wiped down with a bleach wipe before and after use. V3 said the nurse should rub the glucometer with the wipe to remove germs, bacteria, or blood from the machine between use. V3 said the glucometer shouldn't just be sitting in the wipe, there needs to be some friction to prevent cross-contamination. V3 said the bleach wipes are single use and should not have been re-used. The facility's undated List of Residents requiring blood glucose monitoring with the blood glucose test machines included R14, R17, R12, R4, R8, and R21. The facility's Cleaning and Disinfecting of Glucometer Policy dated 6/9/10 showed, The blood glucose meters will be cleaned between each resident test to avoid cross contamination issues. Procedure: 1. Cleaning and disinfecting with a germicidal disposable wipe will be completed each time the blood glucose meter is used with a pre-moistened towelette. 2. Using gloved hands remove and unfold the wipe. 3. Wipe down area to be cleaned. 4. Air dry . 2. On 9/4/24 at 8:48 AM, V3 (LPN) used the wall-mounted hand santizer dispenser. V3 stated, Oh, that's way too much, massaged some of the sanitizer into her hands, then wiped the palms of her hands down the legs of her scrub pants. V3 prepared R14's G-tube medications and blood glucose testing supplies. V3 applied a gown and gloves. V3 stopped R14's feeding pump, disconnected the tubing for R14's feeding, and set the end of the tubing directly on R14's gown. V3 did not place a cap over the open end of the feeding tube. The tip of the tube feeding tubing was in direct contact with R14's gown and chest. V3 attached a syringe to R14's G-tube to check for residual. V3 then removed the syringe from the G-tube, looked down and picked up the tube feeding tubing from R14's gown. V3 placed a cap over the end of the tubing and hooked it on the tube feeding pole. V3 administered R14's G-tube medications and flushes. R14's Facesheet dated 9/4/24 showed he had diagnoses to include, but not limited to: multiple sclerosis, gastrostomy tube (G-tube), lack of coordination, generalized muscle weakness, hypothyroidism, GERD (gastro-esophageal reflux disease), and major depression. R14's September 2024 MAR showed two medications to be administered through his G-tube at 8:00 AM (Famotidine (antireflux) 40 mg and Haldol (antipsychotic) oral concentrate 2mg/ml - give 0.5 ml). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/24 at 8:58 AM, V2 (DON) said the nurses can use hand sanitizer during medication pass. They should apply the hands sanitizer and rub it all over their hands, until it's completely rubbed in. The purpose of hand hygiene is to disinfect their hands and prevent the risk of cross-contmamination. V2 said they shouldn't use their scrub pants to dry their hands because their scrubs could be contaminated. V2 said the tip of the feeding tube should be kept clean, it should never be set directly on the resident. V2 said the nurse should clean the tip of the tubing with an alcohol wipe and hook it on the pole to prevent it from coming into contact with anything. The risk of it becaming contaminated is very high if it's not kept clean. The facility's Medication Administration Policy dated 11/18/17 showed, .Procedure: .12. Appropriate hand washing is to be completed and/or alcohol based gel rub . must be used, throughout medicaiton pass. This should occur: before and after medication pass . The facility's Hand Hygiene Policy dated 12/7/18 showed, All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contanct and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them is an important component of infection control and isolation precautions . If soap and water are not available, alcohol gel/rub to clean your hands. 1. Apply product to palm of one hand. 2. Rub hands together. 3. Rub th product over all surfaces of the hands and fingers until hands are dry. 20042 3. On 9/3/24 at 9:36 AM, V4 (Respiratory Therapist) and V3 LPN (Licensed Practical Nurse) were at R11's bedside for education related to her trach (tracheostomy) and to change R11's trach. V4 stated the head of the bed needed to be flat and pillows removed when the trach is changed. V3 lowered the head of the bed flat and removed the pillow under R11's head. V4 and V3 had gloves on and were at R11's bedside. V4 instructed V3 on how to remove the trach ties. They were unable to get the ties undone and had to cut the trach ties. V3 placed two fingers on either side of the trach to keep it in place. V4 grabbed the new uncuffed number 6 trach with obturator from the container on the bed and put lubricant on the trach. V4 told V3 on the count of three, V3 would pull the old trach out and V4 would immediately place the new one. V3 and V4 counted to three and V3 pulled out R11's old trach. V4 placed the new trach and removed the obturator. V4 and V3 put the trach ties on the trach to secure it in place. V3 raised the head of R11's bed and covered her with a sheet.V3 was asked if they follow enhanced barrier precautions? V3 asked what enhanced barrier precautions were. V3 was shown the sign on R11's door for enhanced barrier precautions (EBP) and the need for gowns and gloves for high cantact resident care activities including device care or use and a tracheostomy. On 9/3/24 at 10:05 AM, V5 CNA (Certified Nursing Assistant) and V6 CNA came into R11's room to provide incontinence care and reposition R11 in her bed. V5 and V6 had gloves on but did not have a gown on. V5 and V6 laid R11's bed flat, stated she was set, removed her soiled brief, and provided pericare/incontinence care. V6 changed R11's gown. V5 and V6 put a clean incontinence brief on R11 and clean incontinence pad under her. V5 and V6 repositioned R11 and covered her with a sheet. V5 stated they only wear glves when providing care for R11. V5 and V6 were shown the sign for enhanced barrier precautuons on R11's door. V5 and V6 stated they should be wearing gowns and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/4/24 at 11:07 AM, V2 DON (Director of Nursing) stated enhanced barrier precautuons are utilized when staff go in to provide high contact care like tube feeding and tracheostomy care. V2 stated staff should wear gown and gloves. V2 stated the EBP signs are posted and there is a container with isolation equipment outside of the room. The Face Sheet dated 9/4/24 for R11 showed medical diagnoses including anoxic brain damage, chronic respiratory failure, tracheostomy, dysphagia, colostomy, autistic disorder, anemia, epilepsy, contracture, and cerebral palsy. The Care Plan dated 8/15/24 for R11 showed, Implementaion of enhanced barrier precaution due to indwelling medical device without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO (Multi-Drug Resistant Organism). Use enhanced barrier precautions during high contact care activities The facility's Enhanced Barrier Precautions (EBP) policy (7/13/23) showed, enhanced barrier precautions should be used when contact precautions do not apply for residents with any of the following: .idwelling medical devices Enhanced barrier precautions require the use of a gown and gloves during high-contact resident care activities that provide opportunities for the transfer of MDRO's (multi-drug resistant organisms) to staff hands and clothing. EBP is primarily intended to use for care that occurs within a resident's room, when high-contact resident care activites are bundled together. High-contact care activities include: dressing, bathing/showering, transfers, hygiene, changing linens, changing briefs or toileting, caring for medical devices (i.e. central lines, urinary catheters, feeding tubes, tracheostomies, drainage tubes, ports). 4. On 9/3/24 at 12:14 PM, R1 was laying on his back in bed for incontinence care. V5 CNA (Certified Nursing Assistant) and V6 CNA had gloves on, a plastic bag on the floor and disposable wipes on the bed. V5 took a disposable wipe, cleaned one side of R1's groin and discarded the wipe. V5 grabbed another disposable wipe, cleaned the other side of his groin and disposed of the wipe. V5 grabbed a clean incontinence brief and placed under R1's left buttock. V6 turned R1 towards V5 CNA, and took a disposable wipe to clean his buttocks. V6 did not change her gloves. V6 closed the incontinence brief on R1 and pulled his shirt down and his pants up. V5 removed her gloves and left the room to get a sling. V5 came back into R1's room and put gloves on. V6 still had the same gloves on. V5 and V6 put the sling under R1, rolling him back and forth until it was under him correctly. V5 and V6 attached the loops of the sling to the mechanical lift. V6 operated the mechanical lift while V5 guided R1 to his chair. On 9/3/24 at 12:28 PM, V6 CNA stated after doing incontinence care she should remove her gloves and use hand sanitizer before touching anything else because her hands are dirty and things can get contaminated. On 9/4/24 at 11:07 AM, V2 DON (Director of Nursing) stated gloves should be changed after incontinence care is provided and before they touch anything else. V2 stated staff have been working with urine or feces and they don't want that to come in contact with anything else. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan dated 7/17/24 for R1 showed, the resident is rarely or never able to perform activities of daily living without weight bearing/hands on assist of 1/2 care givers or dependent for cares related to confusion/decline in cognition, fatigue, impaired balance, limited mobility, and shortness of breath. R1 has bladder incontinence related to activity intolerance, confusion, and impaired mobility. R1 uses disposable briefs. Change when soiled and as needed. Monitor/document for signs/symptoms of urinary tract infection. The Face Sheet dated 9/5/24 for R1 showed diagnoses including cerebral infarction, dementia, abnormal posture, urinary tract infection, parkinson's disease, sepsis, anxiety disorder, benign prostatic hyperplasia with lower urinary tract symptoms, epilepsy, pneumonia, bipolar disorder, schizoaffective disorder - bipolar type, major depression, schizophrenia, contracture, and muscle weakness. The facility's Perineal Cleansing policy (12/2017) showed, wash pubic area, including inner aspect of both thighs as well as penis and scrotum. Rinse area in same sequence, if applicable. Place soiled items in plastic bag. Remove gloves and wash hands with soap & water, cleansing gel

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 39537 Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary environment. This effects all residents residing in the facility. The findings include: The facility's CMS 671 Form dated 9/3/24 showed 21 residents resided in the facility. On 9/3/24 at 8:30 AM, residents were seated in the main dining area. There was a rectangular hole (larger than my clipboard that measures 14 x 10 inches) in the ceiling. There was a plastic tunnel extending from the opening in the ceiling, into a large, wheeled garbage can. The can was surrounded by a dining room chairs, arranged in a circular fashion, and wrapped with yellow caution tape. The ceiling area surrounding this opening had bubbling and peeling of the drywall and appeared to have had new paint applied to some areas. Inside the activity room there was a large (greater than a foot diameter), circular shaped hole in the ceiling. There was a plastic tunnel extending from the hole into a wheeled garbage can. The ceiling around this open area was drooping. The drywall had bubbling and peeling extending from the hole 1-2 feet. The ceiling appeared to have severe water damage in the past. At 9:10 AM, the surveyor viewed the roof from the ground-level. The roof was in general disrepair with numerous missing or damaged shingles. There were several areas in the rear patio area, where the various levels of the roof met. These areas had heavy shingle damage. The roof vent at the peak of the roof had shingles that were bent in odd directions or missing. They were not laying down flat, in a fashion to prevent water from entering the facility. On 9/3/24 at 10:36 AM, V10 (Maintenance Director) said today was his first day, so he was unsure how long the holes had been in the ceiling. V10 said it looks like the roof is leaking and we need to put up some plastic sheeting on the roof to cover the rough patches. V10 said the plastic sheeting should prevent the moisture from getting into the ceiling in the first place. The plastic sheeting would be a temporary fix until the roof could be repaired. Then we can patch the holes in the ceiling. On 9/03/24 at 11:24 AM V6 (CNA - Certified Nursing Assistant) said the hole in the dining room had been there for weeks and the one in the activity room had been there months. V6 stated, I'm sure there's mold in there. We haven't been getting much rain, so there hasn't been much water in there lately. All I know is the previous Maintenance Director (V11) was told to cut those holes in the coiling) and then he ended up leaving. The residents were starting to arrive to the dining room for the noon meal. Multiple residents ate in the dining room throughout the survey. On 9/3/24 at 1:52 PM, during the Resident Council Meeting the residents said the hole in the activity room had been there 2-3 months and the hole in the dining room was only 2-3 weeks. They said, It was pretty wet for a while, but there hadn't been much rain, so it was finally drying out. It's an eyesore. We need a new roof, but they (facility management) don't discuss that with us. No one had been doing any work on fixing the issue lately. They said [V11- Previous Maintenance Director] took another job. The Resident Council Meeting was held in the activity room (with the large circular hole in the ceiling) and 5 residents attended. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/4/24 at 11:19 AM, V1 (Administrator) said the roof was leaking and the corporate office told us to cut a hole in it so it wouldn't spread. V1 said [V11 - Previous Maintenance Director) made the drainage spots to keep it from making too much of a mess. V1 said the shingles on the roof are compromised and because of the way the shingles lay, the rain gets in. V1 said the building needs a new roof. V1 said this time the roof was really leaking. The ceiling in the activity room has leaked before and all they did was tar it, but it leaked again. V1 said the facility does not have a building maintenance policy. V1 said the facility does not have a maintained or repairs log. V1 said she may be able to find some emails about the room to provide a better timeline. At 1:45 PM, V1 provided an email from V17 (Regional Maintained) dated 9/4/24 and said this is all I have. V1 said there had been texts and phone calls between V11 and V17, but she didn't have those. V17's (Regional Maintenance) email dated 9/4/24 showed, The roof damage incurred at [the facility] by 2 separate storms in late July 2024 have been assessed and quotes have been obtained for repairs and replacement (the facility was unable to provide these to the surveyor). Maintenance staff has done all necessary temporary repairs and cautions to isolate the leaks until all permanent repairs of the roof system and drywall ceiling are able to be scheduled by an approved contractor. 20042 2. On 9/3/24 at 9:36 AM There was a fan on the wall in R11's room that was turned on and pointed directly on R11. The fan had dust all over the front blade cover including large fuzzy gray clumps of dust. V3 LPN (Licensed Practical Nurse) and V4 (Respiratory Therapist) were at R11's bedside changing her tracheostomy tube. On 9/5/24 at 9:56 AM, R11 was laying on her back in bed. R11's tracheostomy tube was in place. R11's mouth was open while she was sleeping. R11's fan was turned on and pointed directly on R11. The fan had dust all over the front of the fan including large fuzzy gray clumps of dust. On 9/5/24 at 9:57 AM, V2 DON (Director of Nursing) was walking down the hall and was asked to stop at R11's room and observe R11's fan. V2 looked at the R11's fan and stated the fan was very dirty and was blowing right on R11. V2 stated housekeeping or maintenance can clean the fan. V2 stated they had a maintenance man that started a few days ago. V2 stated V18 (Housekeeper) should clean the fan as often as it needs to be cleaned. On 9/5/24 at 10:04 AM, V18 (Housekeeper) stated she does housekeeping and laundry. V18 stated there is a housekeeper that works part time. V18 stated she is here every day for 10-12 hours per day. V18 stated when the resident's rooms are cleaned they are cleaned from top to bottom. V18 stated maintenance is supposed to clean R11's fan. V18 stated the facility has not had a maintenance person in awhile. R11's fan has probably not been cleaned in a really long time and is probably nasty. V18 stated resident rooms are not cleaned every day. V18 stated she doesn't have time. The Face Sheet dated 9/4/24 for R11 showed medical diagnoses including anoxic brain damage, chronic respiratory failure, tracheostomy, dysphagia, colostomy, autistic disorder, anemia, epilepsy, contracture, and cerebral palsy. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Care Plan dated 8/15/24 for R11 showed, implementation of Enhanced Barrier Precaution due to indwelling medical device without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO (multi-drug resistant organisms). Nutritional status is nothing by mouth; all nutrition is given through a feeding tube. R11 has limited physical mobility related to contractures, neurological deficits, and weakness. R11 has impaired cognitive function or thought processes. R11 has a tracheostomy related to impaired breathing mechanics. The facility's Housekeeper Job Summary (no date) showed, clean, organize and sanitize each resident room, all hallways, congregate areas, nursing station and offices at least once a day. Dust high and low areas and wipe marks and spots from walls, woodwork, furniture, doors, etc. daily.