STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146195	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical McHenry	550 Ridgeview Drive McHenry, IL 60050

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on interview and record review the facility failed to implement a treatment for a stage II pressure injury for two days. This applies to 1 of 3 residents (R49) reviewed for pressure injuries in the sample of 18. The findings include: R49's progress notes showed she was sent from the facility to a local area hospital on 7/20/24. R49's progress notes showed she was admitted to the hospital for a lung abscess and diarrhea. R49's progress notes showed she was admitted back to the facility on [DATE]. R49's 8/10/24 Admission Note from 6:00 PM showed, Sacrum (area above buttocks) open areas and redness. (The note does not document any treatment was applied or any notifications were made.) R49's 8/12/24 Sacral Wound Assessment showed the wound was a stage II pressure injury, it was open, it was draining, and it was present on admission. The assessment was authored by V5 Certified Wound Care Nurse. R49's August 2024 Treatment Administration Record (TAR) showed the first documented wound treatment for her sacrum was completed on 8/14/24. On 8/22/24 at 10:51 AM, V5 stated the wound was identified as a stage II pressure injury and it was found during R49's readmission skin assessment. V5 stated the wound is improving. V5 stated 8/10/24 was a Saturday and he works Monday through Friday. V5 stated he assessed and treated the wound on 8/12/24. V5 stated the nurse who identified the wound should have called him or R49's provider for treatment orders, applied the treatment, and documented application of the treatment. V5 stated these steps were not documented as being done and there is no evidence of treatments being applied until he assessed the wound on 8/12/24 (two days after the wound was identified). V5 said, the importance of treating wounds is to prevent worsening of the wound and to possibly prevent infection. V5 said, In this case the nurse should have called me for treatment orders until I came in on Monday and then document that it was treated. In this case that was not done. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Wound Policy and Procedure (dated March 2020) showed, .Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. Typically, the goal is one of promoting healing and preventing infection unless a resident's preferences and medical condition necessitate palliative care as the primary focus . The policy showed, Discussion with the attending physician and resident/representative includes notification of any skin impairment identified on admission. Orders are verified or obtained as needed .

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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** 34891 Based on observation, interview, and record review the facility failed to supervise a resident with swallow precautions while eating for 1 of 4 residents (R174) reviewed for safety in the sample of 18. The findings include: R174's face sheet printed on 8/21/24 showed admitting diagnoses including but not limited to Parkinson's disease, pneumonitis due to inhalation of food and vomit, chronic obstructive pulmonary disease, and dysphagia (difficulty swallowing). R174's admission assessment dated [DATE] showed no cognitive impairment, no natural teeth, and the use of dentures. R174's physician orders showed orders start dated 8/16/24 for a mechanical soft diet and may suction as needed. On 8/21/24 at 9:36 AM, R174 was in bed and alone in his room. A breakfast tray of cut up pancakes and sausage was in front of him. A bowl of applesauce and glass of juice were on the tray. R174 was feeding himself and coughing intermittently. A sign was posted on the wall that showed 1:1 feeder (one to one feeding assistance). A second sign showed safe swallow instructions including use slow rate, set up assistance, small bites, and sips. On 8/21/24 at 9:47 AM, R174 could be heard from outside the room repeatedly coughing. R174's dentures were laying on top of his lap. He had a suction tube in his mouth and was suctioning himself. V9 (Certified Nurse Aide) was outside the room door and was alerted. V9 stated that is typical for him. He has pneumonia and coughs a lot. He has his own suction machine and refuses to let anyone else suction him. V9 said R174 needs staff assistance at meals because he coughs so much. V9 entered R174's room and exited less than one minute later. R174's breakfast tray remained in front of him. On 8/21/24 at 9:52 AM, V3 (Regional Nurse) entered the room and observed R174 coughing and suctioning himself. V3 asked R174 if he was okay, and he replied that stuff (food) is clogging me up. V3 exited to notify the floor nurse and obtain a pulse oximeter. R174 said he can't get anyone to help him with his morning cares. V8 (Registered Nurse) entered the room and observed R174. R174 was calm and had stopped coughing. V3 resettled R174 and said he does feed himself at meals. V3 exited the room and the breakfast tray remained in front of R174. On 8/21/24 at 1:49 PM, V10 (Therapy Director) stated residents with dysphagia have trouble swallowing and R174 has been evaluated by the speech therapist. The evaluation showed he needs help with meals and a mechanical soft diet texture. He is unsafe eating alone due to poor attention, impulsive, and needs small bites. Residents that are 1:1 feeders definitely need staff present at meals. On 8/21/24 at 1:59 PM, V4 (Director of Nurses) and V3 (Corporate Nurse) were interviewed at the same time. The nurses stated staff need to be present at all times for any 1:1 feeder. It is for safety and to reduce the potential of choking. V3 said R174 should not have been eating alone. Staff should have remained with him or removed the food tray. The posted swallow precautions should have been followed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Meal Service policy last revision dated 5/2024 states under the procedure section: 11. Residents are encouraged to eat by all facility staff. If a resident needs to be fed/assisted, they are fed/assisted.

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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** 36186 Based on observation, interview and record review the facility failed to monitor residents while taking Physician Prescribed medications for 2 of 3 resident (R1, R32) reviewed for medication administration in the sample of 18. The findings include: 1. The facility face sheet for R1 shows she was admitted to the facility with diagnoses to include chronic obstructive pulmonary disease, type 2 Diabetes Mellitus, congestive heart failure and chronic lymphocytic leukemia. The facility assessment dated [DATE] shows R1 to be cognitively intact and is dependent on staff for her activities of daily living. On 8/21/24 at 2:34 PM, R1 said the night nurse V16 Licensed Practical Nurse brings her morning medications to her at 5 AM. R1 said she wears a CPAP and it takes her a minute to remove this and to wake up enough to take pills at that time of the day. R1 said V16 just leaves the medicine on my table, gives me my insulin and leaves the room. R1 said most times she drops the medications so they never get taken. R1 said there was a pill on her bed right now she just noticed. (A beige rounded square pill was observed on R1's bed) R1 said the pill was her singulair she takes to help her breathing. On 8/22/24 at 10:54 AM, V15 LPN said, Medications can only be left at the bedside if we have a Physician order for it, otherwise the nurse must give the resident their medications and stay with them while they take them. It's for safety reasons, so another resident doesn't take them and to make sure the residents get their medications as ordered. On 8/22/24 at 11:17 AM, V4 Director of Nursing (DON) said, Medications should never be left at the bedside for a resident to take alone. We are documenting the residents are taking them, we need to stay and watch them take the medications. The Physician Order Sheet (POS) for R1 dated August 2024 shows an order for montelukast sodium (Singulair) oral tablet 10 mg at bedtime. The Medication Administration Record (MAR) dated August 2024 for R1 shows the medication montelukast sodium oral tablet 10 mg is to be given at 9 PM. The MAR for R1 shows 2 medication tablets are ordered for 6 AM and they are for hypertension and a thyroid replacement. 39543 2. On 8/20/24 at 10:46 AM, R32 was eating breakfast on the edge of her bed. To the left of R32's, sitting on top of her refrigerator, was a cup with at least 12 pills. On 8/20/24 at 10:46 AM, R32 said, I like to take the pills after I eat so I told her just to leave them and I would take them when I'm done. Sometimes they leave the pills, sometimes they don't. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 12:26 PM, R32's electronic Care Plan showed no interventions for medications to be left at the bedside. On 8/21/24 at 12:30 PM, R32's electronic physician orders showed no orders for medications to be left at the bedside. R32's August 2024 Medication Administration Record (MAR) showed the following meds were documented as being given for R32's 9:00 AM med pass: Aspirin 81 milligrams (mg); Iron supplement; Folic Acid supplement; Furosemide (diuretic/water pill); Isosorbide (diuretic); Metoprolol (treatment of high blood pressure); Multivitamin; potassium; probiotic; Vitamin D; Bactrim (Antibiotic); Cilostazol (medication to improve blood flow in legs); and hydralazine (treatment of high blood pressure). On 8/21/24 at 1:44 PM, V2 Director of Nursing stated, nurses should monitor residents while they take their medications. V2 said, if R32 wanted to wait to take her medications the nurse should have held on to the medications and returned after she finished breakfast. V2 said it is important to monitor residents while they take their medications to ensure the medications are taken by the resident and to ensure the resident does not drop any pills on the floor. V2 said the nurse is documenting the medications were given, which is not possible if he/she does not actually watch the resident take the medications. V2 said if R32 wanted to be able to take medications by herself, R32 would not to be assessed for safety, the physician would have to agree, and care plan interventions would need to be put in place. The facility's Administration of Medications procedure (revised 4/2024) showed, .Remain with the resident to ensure that the resident swallows the medication. Once resident takes the medication hit 'save' on the eMAR.

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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 refrigerated foods were properly stored and labeled and failed to ensure hairnets were in place. This affects all residents residing in the facility. The findings include: The facility's CMS form 671 dated 8/20/24 showed 75 residents resided in the facility. On 8/20/24 at 9:56 AM, V11 (Dietary Manager) accompanied the surveyor during the kitchen tour. A pan of raw, chicken thighs was marinating in a metal pan on the shelf. This pan was partially covered with loose saran wrap. The end of the saran wrap was curled back, exposing the raw chicken. The metal pan was labeled with a prepared dated of 8/13/24 and a use by date of 8/19/24. V11 said this meat is marinated ahead of time, then the dietary staff will seal it in vacuum, freezer bags and use it the pre-marinated meat at a later date. V11 said the meat should have been frozen prior to the 8/19/24 use by date, on the label. V11 stated, I'll have to throw this out. V11 said the food is labeled to ensure the food quality and to prevent foodborne illness. There was a small, metal tray of sliced ham that had loose saran wrap. The saran wrap was peeling back and the meat was exposed. V11 said the ham was for the noon meal today. (The sliced ham was used for the noon meal). The surveyor asked V11 if the food should be covered and V11 replied, Yes, the saran wrap needs to provide a tight seal or they should be placing lids on the food to prevent cross-contamination. A large pork loin (5-10 pounds) was at the bottom of a storage rack, resting on a shallow pan. There was no food label on the pan or the pork loin. V11 picked up the pan and rotated it, looking for the label with the dates. V11 stated, This doesn't have a label, but there is a 16 written on here in marker. The surveyor asked how does he know what the 16 means and he replied, I'm sure it's because it was put in here on the 8/16. V11 said there should be a white label with the date the pork loin was pulled and the use by date. V11 obtained a label and placed pan holding the pork loin. At 12:16 PM, V12 (Dietary Aide) was standing near the food preparation area, steam table, and tray assembly line. V12's blonde bangs were outside of the hair net. V12 moved throughout the kitchen, with her hair outside the hair net until 12:38 PM, when the surveyor pointed it out to V11 (Dietary Manager). During this time, V12 was standing near a baking sheet of ham sandwiches, preparing resident meal trays, obtaining beverages from the walk-in refrigerator and moving about the kitchen area. At 12:28 PM, the surveyor asked V11 (Dietary Manager) if all hair should be contained in the hair net. V11 said all staff in the kitchen should have their hair restrained to prevent hair from falling in the food. V11 asked, Why are you asking me this? Is someone not wearing the hairnet properly? The surveyor pointed out V12, in the tray assembly area. V11 informed V12 that all her hair must be in the hair net. The facility's Week 2 Menu printed 8/20/24 showed on 8/20/24 the noon meal consisted of: Sweet Baked Ham & Cheese Sandwich, Homemade Sweet Potato Wedges and Pineapple Tidbits. (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 Refrigerated Food Policy dated 2021 showed, Refrigerated food prepared in the healthcare community is labeled with the date to discard or to use by . Refrigerated Potentially Hazardous Food (PHF) or Time/Temperature Controlled for Safety (TCS) foods are labeled with the date received and if not opened, are discarded by the manufacturer's expiration dated. If opened, the cold food item is labeled with the date opened and the date by which to discard or use by . The facility's Storage of Frozen Foods showed, .Appropriate storage procedures are followed, First-In-First-Out (FIFO) . If taken out of the original container, food is tightly wrapped and labeled with the name of the item and use by date . Frozen foods can deteriorate in quality the longer they are stored. Therefore, frozen foods are best if used within 3 months . Opened products that have not been properly sealed and dated are discarded . The facility's Hair Restraints/Jewelry/Nail Polish/False Eyelashes Policy dated 2021 showed, Food and nutrition services employees shall wear hair restraints and beard guards . Hairnets will be worn at all times in the kitchen .

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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** 34891 Based on observation, interview, and record review the facility failed to ensure isolation precautions were maintained to prevent cross contamination for 2 of 7 residents (R61, R49) reviewed for infection control in the sample of 18. The findings include: 1. On 8/20/24 at 10:55 AM, R61 was lying in bed on a pressure reduction mattress and an intravenous catheter (IV) line was visible in her right upper arm. R61 was fully alert and oriented. R61 stated she has a sore on her buttocks and needed an IV antibiotic to treat an infection she had in her urine. R61's room door did not have any type of signage or precautions posted. Other resident rooms on the same hallway showed signs that indicated enhanced barrier precautions were required for residents with wounds or invasive medical devices. On 8/20/24 at 12:44 PM, a newly placed isolation sign and PPE (personal protective equipment) were noted on the door of R61's room. The sign showed contact isolation precautions and PPE needed prior to entering the room. R61's August 2024 physician order report was reviewed and showed an order start dated 8/15/24 for: Contact isolation for ESBL in urine (6 days ago). R61's care plan showed a focus area for contact isolation related to ESBL in her urine. Interventions included: Verify that proper isolation notifications are in place and appropriate protective equipment inside and outside room and follow policy for contact isolation. (start dated 8/15/24) On 8/21/24 at 10:02 AM, V7 (Registered Nurse) stated R61 has in infection in her urine. She needs to be on contact isolation for the ESBL (extended spectrum beta-lactamase). She has had an order for the contact isolation since 8/15/24. The room needs the signage and PPE outside the door as soon as the infectious germ is discovered. All staff need to put on a gown and gloves before they enter the room. It stops the germ from spreading to surfaces and getting outside the room. This surveyor donned the PPE and entered R61's room. There was no specialized disposable bin for used PPE. R61 was asked about the isolation signage on her door and stated she had no idea why it was there. R61 said some staff wear gowns and gloves in the room and others do not. R61 said it varies between shifts. At 10:14 AM, V7 (RN) stated rooms on contact isolation need red garbage bins in their rooms for used PPE. The red bins show it is biohazardous material and is disposed of differently that regular garbage. R61's facility assessment dated [DATE] showed no cognitive impairment or memory problems. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 9:55 AM, V2 (Director of Clinical Operations) and V6 (Assistant Director of Nurses) were interviewed together. The staff stated isolation signs and PPE are necessary to protect the residents from germs. The sign shows what PPE needs to be worn and what type of isolation is in use. Contact isolation needs to be started the same day as the physician order is received. It should be posted immediately so staff are aware. It is important to stop the spread of the specific organism or germ. V6 said contact precautions supersede enhanced barrier precautions. Residents on either type of isolation need signs and PPE outside their room doors. R61 should have had PPE, signage, and a biohazard bin available the same day the isolation precautions were ordered. The facility's Infection Control policy last revision dated May 2024 states: When a resident is placed on transmission-based precautions, facility's Infection Preventionist will implement the following but is not limited to: Clearly identify the type of precaution and appropriate PPE to be used. Place signage that includes instructions to see the nurse prior to entering the room. Make PPE readily available near the entrance to the resident's room. 39543 2. On 8/21/24 at 10:00 AM, R49's door showed a blue contact isolation sign. The sign indicated gloves and a gown were required for entry. On 8/21/24 at 10:00 AM, V5 Certified Wound Care Nurse entered R49's room. V5 did not have a gown or gloves on. R49's quilt was draped over the foot of her bed. V5 rested both of his hands on the quilt that was draped over the foot of the bed. R49's 7/21/2024 at 6:34 AM Nurses Note showed she was admitted to a local area hospital for C-Diff (a multi-drug resistant organism/MDRO which can cause severe diarrhea) and a right lung abscess. R49's Progress Notes showed she returned to the facility on [DATE]. R49's Order Summary Report (Physician Order Sheet/POS) showed, as of 8/21/24 an order for Contact Isolation for C-diff. On 8/21/24 at 1:44 PM, V2 Director of Nursing stated, the importance of wearing gowns and gloves when entering a contact isolation room is to prevent the spread of infection to staff and other residents. V2 said, V5 should have been wearing a gown and gloves when he touched R49's bedding. The facility's Infection Control Policy (rev May 2024) showed, Contact Precautions are implemented most often for residents who have an infection due to an epidemiologically important organism such as multi-drug resistant organism (MDRO). Staff are to don gowns and gloves upon room entry and doff gowns and gloves and perform hand hygiene prior to exit of resident room.