STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39744 Based on interview and record review the facility failed to ensure physical restraints were used to treat a medical symptom and failed to provide evidence of least restrictive methods attempted prior to initiating a physical restraint for 1 of 2 (R10) residents reviewed for physical restraints in a sample of 28. Findings include: According to the Physician's order sheet dated [DATE] through [DATE], R10 was admitted to this facility on [DATE] and has diagnosis listed as: Constipation, Cough, Depression, Dementia, Hypertension, Hypothyroidism, Degenerative Joint Disease, Anxiety, Vitamin D Deficiency, GERD (Gastric Esophageal Reflux Disease), Osteoporosis, Malignant Neo of Ascending Colon, Anemia, Hypokalemia, Pneumonia, Nail Dystrophy, Corns and Callosities, and General Atherosclerosis. R10's most recent MDS (Minimum Data Set) dated [DATE] under section C, E and G shows R10 has severe cognitive impairment and is rarely or never understood, is completely dependent on staff for transfers, toileting, eating, dressing, bathing, does not walk, does not exhibit hallucinations or delusions, no physical or verbal behaviors and does not resist care. On [DATE] at 1:30pm, V3 (MDSC-Minimum Data Set Coordinator/CPC-Care Plan Coordinator/ LPN-Licensed Practical Nurse/ IP-Infection Preventionist) said the facility has two residents who wear a physical restraint while up in their wheel chairs called a Lap Buddy. V3 said this type of restraint is made of thick foam that wedges into the front part of the wheel chair and hooks around the wheel chair arm rests to prevent the resident from standing up and freely moving out of the wheel chair. V3 said R10could not independently remove the device making it a true restraint in her opinion. V3 said the other resident could independently remove the restraint, so it was not a true restraint. V3 said R10's physician ordered the device on [DATE] due to increased fall risk. V3 said R10's last fall was documented on [DATE] and R10 ' s last fall risk assessment was completed on [DATE]. When asked why R10 had a physical restraint applied in May after no falls since [DATE] and no changes in her fall risk assessment, V3 said the nursing staff though it would be a good idea to help with positioning, so they asked R10's doctor and he agreed to order the device. V3 said they did not try any less restrictive interventions before placing the physical restraint on R10's wheel chair. V3 said she had not worked at this facility very long and did not know what interventions were attempted prior to V3 starting the MDSC/CPC position in [DATE]. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's medical record under the Physician's order section contained a copy of a document that represented an electronical communication to the facility from R10's medical doctor. The order documented Order per (V10's physician) Lap Buddy for wheelchair, increased fall risk. A review of R10's care plan and medical record verified no documented diagnosis or symptom the restraining device was ordered to treat and R10's care plan made no mention of the restraining device, how it was to be used and monitored nor a plan for restraining device reduction of use. On [DATE], V3 presented a facility document titled Physical Restraint/Enabler assessment dated [DATE], in which R10 had been assessed for restraint usage. The directions on this document read: Directions: This assessment shall be completed prior to initiation of any alterative device of physical restraint or enabler. According to this assessment, under the heading titled Physical and Mental Considerations, it documents R10 as being alert, with a short attention span, totally disoriented, has poor balance while sitting, falls forward, leans sideways, slides down, can not recover her balance while sitting and has impaired range of motion to both upper and lower extremities. Under diagnosis/medical symptoms for restraint usage it lists, Dementia and Vit D def (Vitamin D Deficiency). Page two of the Restraint assessment has a section with 24 examples of common types of lesser restrictive alternatives with directions to describe the outcomes along with the dates attempted, however none of the boxes are checked and nothing had been documented concerning dates. V3 presented another facility document titled Fall Risk Assessment for R10 on [DATE] in which R10 scored a 15 showing R10 was high risk for falls. Both assessments are dated [DATE] and both completed by V3. On [DATE] at 9:00am, V3 (MDSC-Minimum Data Set Coordinator/CPC-Care Plan Coordinator/ LPN-Licensed Practical Nurse/ IP-Infection Preventionist) said R10 had passed away during the night on [DATE]. V3 said R10 had severe contractures to both her upper extremities and could not use her hands to grasp a fork to feed herself and severe limited range of motion to both her legs. V3 said R10 did not attempt to get out of her wheel chair by standing up, but instead would lean forward and fall out of her wheel chair. V1 (Administrator/Registered Nurse) and V3 said the facility had contracted therapy staff who came to the facility everyday but had not considered asking the therapy department to assess R10 for better wheel chair positioning to prevent leaning out of the chair. After reviewing R10's medical record and care plan, V3 could not locate what medical symptom/diagnosis the restraint was order to treat and could not find a plan of care for how the restraint was to be used, why the restraint was being used and what type of monitoring the restraint needed for the safety of R10 during use. V3 said she was new at her position and did not know this type of device could not just be applied for R10 ' s safety. On [DATE] at 2:30pm, V3 said she was not familiar with the facility's restraint policy. V3 said since staff applied the device to R10 ' s wheel chair they had not attempted any form or restraint reduction. On [DATE] at 9:30am, V1 (Administrator/Registered Nurse) said the facility has not been having ID (Interdisciplinary) Team meetings because she did not know until last week that they were supposed to be having them. V1 said she began working at this facility back in [DATE] as the Director of Nursing and was promoted to Facility Administrator in [DATE]. V1 said she did not know less restrictive interventions should have been attempted prior to applying the restraining device to R10 ' s wheel chair. V1 said she was not familiar with the facility ' s physical restraint policy. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], [DATE], and [DATE] no observations of R10 could be made of her up in her wheel chair. R10 was ill and remained in bed during the survey. R10 expired on [DATE]. A facility policy titled Physical Enabler/Restraint Policy with last revision date of [DATE] documents in part the following procedures to be followed for physical restraint use, 1. Complete Physical Enabler/Restraint Use/Reduction Evaluation. 2. Obtain verbal and/or written consent from resident/legally responsible party (May obtain verbal consent until able to receive written consent). 3. Document in nurses notes the date, time, and which type of consent obtained prior to physical restraint being applied. 4. Obtain M.D. order for restraint or adaptive device/enabler. The order must include: specific medical/physical reason, type of restraint/enabler, release and reposition at least every two hours and when to be used 9. Apply the physical restraint according to the manufacturer directions for the specific type of physical restraint being used. (Only nursing staff trained in the application of the particular type of restraint will be allowed to apply the particular restraint). 10. Attach all ties/loops/ Velcro/or buckle attachments behind or beneath the chair according to the manufacturer's directions. 11. Allow a two-finger width between the resident's body and the physical restraint. 12. Secure all attachments out of reach or line of vision of the resident. 13. Release the physical restraint at a minimum of every two hours. During this period the resident shall be ambulated (if applicable), repositioned, toileted or changed, and/or skin care and nursing care provided, as appropriate. 14. Whenever a physical restraint is used on a resident whose primary mode of communication is sign language, the resident shall be permitted to have his or her hands free from restraints for brief periods each hour, except when this freedom may result in physical harm to the resident or others. 15. Document in nurses notes type of restraint being used and resident's response to the physical restraint. 16. Place physical restraint problem on the resident's care plan. The care plan must address the duration, type, and circumstances under which the restraint can be used. 17. After initial documentation, all physical restraints require quarterly documentation regarding the type of physical restraint used, resident's response to the physical restraint, and if any reduction plan has been attempted. 18. Initiate Restraint Elimination/Reductions Program ninety days from application.

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F 0605 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. 39744 Based on interview and record review the facility failed to ensure the administration of injectable anti-psychotic medications are used to treat medical symptoms and not for the convenience of the staff and failed to attempt less restrictive alternative treatments prior to administering and injectable anti-psychotic medication for 1 of 6 residents (R32) reviewed for psychotropic medications in a sample of 28. This failure resulted in R32 receiving an injectable anti-psychotic medication which R32 resisted without an adequate indication for use which would cause a reasonable person emotional and psychological distress. Findings include: According to R32's Physician Order sheet dated 7/1/2022 through 7/31/2022 R32 was admitted to this facility on 5/20/2022 with diagnosis of Cerebral Infarction, Dysphasia, dysarthria, Hypertension, Atrial Fibrillation, Gastro Esophagitis with bleeding, Benign Prostate Hyperplasia with lower urinary tract symptoms, Obstructive and Reflux Uropathy, Moderate Protein Malaise Malnutrition, Depressive Episode, Restless Leg Syndrome, Chronic Kidney Disease, Anemia, Generalized Muscle Weakness, Change in Bowel Habit, Vitamin Deficiency and Dementia. R32 ' s MDS (Minimum Data Set) dated 5/30/2022 documented R32 with a BIMS (Brief Interview for Mental Status) score of 03 on a scale up to 15 indicating R32 has severe cognitive impairment. It also documented R32 uses a walker and needs extensive assistance of 1 person for ambulation, dressing and most personal hygiene tasks. A Social Service Noted dated 5/20/2022 documents R32 cannot read or write, likes working on items like watches, radios, and broken things. R32 likes the outdoors and mostly likes to stay in his room to watch TV, listen to music or just relax. A Physician's order was noted in R32's medical record, dated 6/4/2022 and showed R32 was ordered an injection of a Psychotropic drug to be given for aggressive behaviors. The order documented as follows 6/4/2022 Give Haldol 5 mg (Milligrams) injection for aggressive behaviors. R32 ' s nurse ' s noted for the date of 6/4/2022 are written as follows and are listed without omissions: Nurse's notes dated 6/4/2022 at 4:15am documented Res (resident) resting in bed quietly with eyes closed. 0 (zero) s/s (signs/symptoms) of distress noted at this time. Will continue to monitor. (the signature of this note is illegible). Nurse's note dated 6/4/2022 at 08:40am and entered R32's medical record by V3 (MDSC-Minimum Data Set Coordinator/CPC-Care Plan Coordinator/ LPN-Licensed Practical Nurse/ IP-Infection Preventionist) dated 6/4/2022 documented Haldol 5mg (Milligrams) injection given in R (right) glute (buttocks). 3 CNAs (Certified Nursing Assistants) assisted with injection. Resident Currently aggravated. Yelling at staff at nurse's desk. Wants his money and wants to go home. R32's physician (V21/Medical Doctor) gave order via phone to (V7/Licensed Practical Nurse) POA (Power of Attorney) notified. Will continue to monitor. (continued on next page)

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F 0605 Level of Harm - Actual harm Residents Affected - Few	Nurse's note dated 6/4/2022 at 1330 (1:30pm) and entered into R32's medical record by V3, documented 0 (zero) behaviors noted at this time. Resident resting in bed. will continue to monitor. R32 ' s nurse ' s notes for the date of 6/5/2022 are written as follows and are listed without omissions: Nurse's note dated 6/5/2022 at 1845 (6:45pm) and entered into R32's medical record by (signature illegible) documented Resident came to NS (Nurse ' s Station) requesting to go home. Was able to redirect resident and resident went back to room to watch tv. Nurse ' s noted dated 6/5/2022 at 1900 (7:00pm) documented Resident was yelling Help this nurse went to res (resident) room and noted resident lying on his bed he stated he wanted to go to the hospital and to go home. On 7/20/2022 at 9:00am, V3 said she was the nurse who cared for R32 on the date of 6/4/2022 and she was the nurse who administered R32 the injectable anti-psychotic medications at 8:40am. V3 said R32 was confused and up at the nurse ' s station requesting his money and to go home. V3 said she tried to talk to R32, but he would not listen and wanted to remain at the nurse ' s station and yell, but she had work to complete. V3 said while she was talking to R32, she felt R32 was becoming more agitated and would become aggressive, so the staff called R32 ' s physician and requested the injectable anti-psychotic medication to calm R32 down. V3 said other than trying to talk with R32, she had not attempted any non-pharmacological interventions prior to giving R32 the injection. V3 said she did not know she was supposed to attempt non-pharma logical interventions and document their outcomes prior to giving R32 the injectable anti-psychotic medication. V3 denied R32 attempting to hurt her, himself, or other residents. V3 denied R32 attempting to destroy property or throw items. V3 denied R32 trying to exit the facility on 6/4/2022 or at any point since his admission to this facility. V3 said it took herself and three CNAs to give R32 the injection. V3 said R32 did not agree with the injection and fought the staff during administration. V3 said the medication did calm R32 and he rested in his room the rest of that day. V3 reviewed R32 ' s care plan and said she could not find any plan of care for behaviors or the use of psychotropic medications. On 7/18/2022 at 2:30pm, V5 (Social Service Director) was asked about what types of behaviors they were monitoring for R32. V5 replied the staff were not doing any specific behavior monitoring because they did not know they were supposed to be doing any. V5 said she thought behavior monitoring meant keeping track of resident-to-resident altercations and said she has not really been trained at her job, V5 said she did not know psychotropic medications need to be prescribed to treat a specific medical symptom/illness and those symptoms/medications needed to be tracked. V5 presented two facility documents titled Behavior Tracking for (R32). Both documents have R32 ' s name written on the top with one form having June 2022 written on it and the other with July 2022 written on it. Both documents are completely blank and do not have any behaviors noted on them. On 7/20/2022 at 9:30am, V1 (Administrator/Registered Nurse) said after R32 was given the injectable anti-psychotic medication, they did not have an ID (Interdisciplinary) team meeting to discuss R32 ' s situation and to update and revise R32 ' s care plan. V1 said they did not do this because they did not know it was supposed to be done. V1 said she has only worked at this facility for a few months and was still learning her job duties. (continued on next page)

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F 0605 Level of Harm - Actual harm Residents Affected - Few	During the survey R32 ' s care plan was reviewed. R32 ' s care plan did not include a plan for behavior monitoring or personalized interventions to attempt if R32 develops agitation. On 07/25/22 at 1:00 PM, V20 (Nurse Practitioner) said she has had a few conversations with the nursing staff at this facility cautioning them about using injectable anti-psychotic medications for immediate behavior control. V20 said for some reason a chemical restraint seems to be their first go to option. V20 said she discussed the need for non-pharmacological interventions to be attempted first. V20 said she also emphasized that just because a resident becomes upset, and yells does not constitute the use of an injectable anti-psychotic medication. V21 (Medical Doctor) could not be reached during this survey therefore V21 ' s Nurse Practitioner (V20) was obtained. A facility policy titled Psychotropic Medication Policy with revision date of 11/28/2018 states Definition of Chemical Restraint: Any medication that is administered with the intent of altering consciousness responsiveness, or to modify behavior, convenience, punishment or discipline. Under the heading labeled Procedure under #2 it states Psychotropic medications shall not be prescribed prior to the attempted non-pharma logical interventions to decrease behavior. Under #7 it states: Any resident receiving such medications shall have a psychiatric diagnosis or documented evidence of maladaptive behavior, which can be considered harmful to themselves or others, destructive to property, or if emotional problems exist which cause the resident frightful distress. Under #19 it states: Any resident receiving any psychotropic medications will have certain aspects of their use and potential side effects addressed in the resident care plan at least quarterly. The care plan will identify target behaviors causing the use of psychotropic medications. The care plan will address the problem, approaches and goals to address these behaviors.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42547 Based on interview and record review, the facility failed to complete an initial comprehensive assessment for 1 of 28 residents (R290) reviewed for assessments in a sample of 28. Findings include: A document titled New Admission Information in R290's medical record documents an admitted [DATE]. A document titled Cumulative Diagnosis Log (undated) documents that R290 has a diagnosis of unspecified dementia without behavioral disturbance, insomnia, and anxiety. Review of R290's medical record did not include any Minimum Data Set (MDS) assessments. On 07/20/22 at 11:45 AM, V3 (MDS/ Care Plan Coordinator/ Infection Preventionist/ Licensed Practical Nurse) said that R290's comprehensive assessment has not been completed yet. V3 said that R290's initial comprehensive assessment is past due and was due on 7/17/22.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42547 Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for 1 of 28 residents (R290) reviewed for care plans in a sample of 28. Findings include: A document titled New Admission Information in R290's medical record documents an admitted [DATE]. A document titled Cumulative Diagnosis Log (undated) documents that R290 has a diagnosis of unspecified dementia without behavioral disturbance, insomnia, and anxiety. A Social Service Progress Note dated 7/6/22 document that R290 is an elopement risk and did try to elope on (R290's) first night here. A Nurse's Note dated 7/18/22 documents that R290 is exit seeking. Nurse's Notes dated 7/13/22, 7/14/22, 7/17/22, and 7/20/22 document that R290 is anxious. R290's comprehensive person-centered care plan could not be located in R290's medical record or interventions in place to monitor/ prevent R290 from eloping or behaviors. On 07/20/22 at 11:45 AM, V3 (Care Plan/ MDS Coordinator/ Infection Preventionist/ Licensed Practical Nurse) said that R290's care plan and comprehensive assessments have not been completed yet. V3 said that V3 has been working the floor and hasn't had a chance to get to it yet.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on Interview and Record Review the facility failed to provide a discharge summary for 1 resident of 1 resident (R40) reviewed for discharge in a sample of 28. Findings Include: An untitled, undated Facility document found in R40's Medical Record documents R40's admitted as 05/03/2022 with an actual discharge date of [DATE]. This document does not denote: R40's diagnoses, course of illness/treatment or therapy, medications, or recapitulation of R40's stay. On 07/20/22 at 9:00 AM there was no discharge summary for R40 located in her Medical Record. On 07/20/22 at 12:25 PM, V1 (Administrator) stated, she does not know anything about a discharge summary for R40, she doubts it was done, but she can look through the chart. On 07/20/22 at 2:10 PM, V1 stated, she found one page of what could have been the start of a discharge summary for R40. On 07/20/22 at 3:45 PM, V1 stated, she could not find a discharge summary for R40.

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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** 42547 Based on interview and record review the facility failed to provide care and treatment in accordance with professional standards of practice for a resident with wounds as ordered for 1 of 6 residents (R8) reviewed for skin condition in a sample of 28. The failure resulted in 2 hospitalization s of R8 for cellulitis of the bilateral lower extremities. Findings include: 1.) The Admission Information Sheet in R8's medical record documents that R8 was admitted to the facility on [DATE]. The Cumulative Diagnosis Log (undated) in R8's medical record documents that R8 has diagnoses including Alzheimer's with behavioral disturbance, anxiety, and bilateral lower extremity (BLE) edema. On 7/19/22 at 12:15 PM, V7 (Licensed Practical Nurse) said that R8 has swelling and weeping of the bilateral lower extremities and gets a daily dressing change. V7 said that R8 used to see a wound care specialist for her legs and has been hospitalized in the past for cellulitis. V7 said the wounds were healed at one point but continue to weep form the edema and they have resumed R8's previous treatment orders. V7 said that a lot of times R8 won't let them do her dressing changes. R8's wound consultation note by V24 (Advanced Practice Nurse-Wound Clinic) dated 3/10/22 documents under Wound Status that R8 has left leg cellulitis with a documented date acquired of 12/26/21. Left leg wound measurements documented are length-20 centimeters (cm), width- 22 cm. A wound consultation on the same date also documents under Wound Status that R8 has right leg cellulitis with a documented date acquired of 2/15/22. Assessment Notes document that the right leg is healed. Physician's Order Details document treatment orders for the wound of the left leg of Apply (silver antimicrobial dressing) to left leg open weeping wounds cover with 4 x4 and abdominal (ABD) pads and wrap with cotton gauze wrap. Change dressing daily and Single layer (elasticized tubular bandage) in the morning upon arising and may remove at night. R8's wound consultation note by V24 dated 3/17/22 documents the left leg wound measurements are length-31 cm, width- 36 cm. The right leg wound measurements documented are length- 4 cm, width- 3 cm. Physician's Order Details document Infectious Disease Consult: bilateral leg cellulitis-tomorrow at 9 AM. R8's Nurse's Note dated 3/18/22 at 0845 (8:45 AM), documents that R8 left the facility to go to an infectious disease appointment. At 1015 (10:15 AM) the same date the Nurse's Note documents that R8 was admitted to the hospital with a diagnosis of cellulitis. A Nurse's Note dated 3/22/22 at 11:35 AM documents that a report from the hospital nurse was received and R8 has an admission diagnosis of BLE cellulitis, has been receiving intravenous antibiotics, and has 2 open ulcers on BLE and R8 will be returning by ambulance. On 7/26/22 at 9:00 AM, V1 (Administrator/ Registered Nurse) said that they do not have any consultation notes from the appointment with the infectious disease specialist and subsequent hospital admission. V1 said R8 was directly admitted to the hospital for cellulitis from the appointment with the infectious disease specialist. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R8's wound consultation note by V24 dated 3/24/22 documents left leg wound measurements are length-23 centimeters (cm), width- 18 cm. A wound consultation on the same date also documents under Wound Status that R8 has right leg cellulitis with a documented date acquired of 2/15/22. Assessment Notes document that R8 has no open areas to the right leg. Physician's Order Details document treatment orders for the wound of the left leg of Apply (silver antimicrobial dressing) to left leg open weeping wounds cover with 4 x4 and abdominal (ABD) pads and wrap with kerlix (cotton gauze wrap). Change dressing daily and Single layer (elasticized tubular bandage) in the morning upon arising and may remove at night. A return appointment in week is ordered. R8's Nursing Home Progress Note dated 3/28/22 by V20 (Nurse Practitioner) documents that R8 has an encounter diagnosis of non-pressure chronic ulcer of other part of left lower leg with unspecified severity and edema of the left lower leg. The note documents that R8 was hospitalized [DATE]- 3/22/22 with cellulitis the BLE. R8's wound consultation note by V24 dated 3/31/22 documents the left leg wound measurements of length- 18 cm and width- 24.5 cm. Physician Order Details document the continuation of the previous visits orders. R8's Physician's Order Sheet (POS) for March 2022 documents a treatment order dated 3/10/22 of Apply (silver antimicrobial dressing) to left leg open weeping wounds cover with 4 x4 and abdominal (ABD) pads and wrap with kerlix (cotton gauze wrap). Change dressing daily and Single layer (elasticized tubular bandage) in the morning upon arising and may remove at night. R8's March 2022 Treatment Administration Record (TAR) documents the orders for treatment of the left leg as documented on the March POS and the wound consultation notes. There are no initials indicating that the treatment of the silver antimicrobial dressing was completed for R8's left leg for 16 days in March. The order for the elasticized tubular bandage application was not initialed as being completed for 15 days in March and the remaining days contained the circled initials of the nurse indicating that the treatment was refused by R8. R8's Nurse's Notes documented that R8 refused the dressing changes on 3/8/22 and 3/10/22. R8's Nurse's Notes on 3/23/22 and 3/30/22 document the dressing was completed, and old dressing removed was saturated with drainage. R8's wound consultation note by V24 dated 4/7/22 documents the left leg wound measurements of length- 19.5 cm and width- 15.5 cm. Physician Order Details document the continuation of the previous visits orders. A new wound with a date acquired documented of 4/5/22 to the left medial leg. The wound type documented is cellulitis with measurements of length- 2 cm, width-2.3 cm, and depth of 0.1 cm. A new wound with a date acquired documented of 4/6/22 to the right leg. The wound type documented is cellulitis with measurements of length- 0.7 cm, width- 0.7 cm. The Physician's Order Detail documents an order to both left and right leg wounds of Apply (silver antimicrobial dressing) to open weeping wounds cover with 4 x4 and abdominal (ABD) pads and wrap with kerlix (cotton gauze wrap) Change dressing daily and Single layer (elasticized tubular bandage) in the morning upon arising and may remove at night. A 2 week return appointment is ordered. (continued on next page)

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Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R8's wound consultation note by V24 dated 4/21/22 documents the left leg wound measurements are now documented as: length- 29.5 cm, width- 22.5 cm. The wound measurements of the left medial leg are now documented as: length 4 cm, width- 4.5 cm, and depth- 0.1 cm. The right leg wound measurements are now documented as: length 15.5 cm, width- 11 cm. Dressings orders are the same as documented at the consultation on 4/7/22. A return appointment is ordered for 2 weeks. R8's April 2022 POS does not document the order for the treatment of the left leg as ordered per V24 on the 4/7/22 wound consultation note. There is no documentation of the order for dressing change on the POS for the right leg as ordered by V24 as documented on the 4/7/22 wound consultation note. R8's April 2022 TAR documents the order for the treatment of the left leg with silver antimicrobial dressing as written per wound consultation notes and POS. The treatment is initialed as being completed 4 times in the month of April. There are no initials indicating the treatment was completed for 26 days in April. There is no new order documented on the April TAR for the treatment of the right leg as ordered on 4/7/22 per V24 as documented on the wound consultation notes from 4/7/22. The order for the elasticized tubular bandage is initialed as being completed one day (4/2/22), initialed and circled as being refused by the resident for 4 days, and the 25 remaining days are left blank. There is no documentation in the Nurse's Notes of R8 refusing the treatments ordered to the BLE in April. On 7/20/22 at 11:30 AM, V3 (Minimum Data Set/ Care Plan Coordinator/ Infection Preventionist/ Licensed Practical Nurse) said that R8 said they do R8's dressing changes depending on what kind of mood R8 is in. V3 said that R8 sometimes doesn't want to get her dressing changes done. A Physician's Telephone Order Sheet dated 5/1/22 documents an order to send R8 to the emergency room (ER) for evaluation and treatment (Tx). There were no Nurse's Notes provided from the facility containing documentation of the rationale for the order to send R8 to the ER. A Transfer Orders for Receiving Facility form from the hospital documents that R8 was admitted to the hospital on 5/1/22 and discharged on [DATE]. The discharge diagnosis documents Cellulitis of both lower extremities. R8's wound consultation note dated 5/18/22 documents under Physician's Order Details a treatment order of apply a single layer (elasticized tubular bandage) to both kegs- apply in the AM and remove at bedtime and an order to Discharge from Outpatient Services. R8's May 2022 POS documents an order to discontinue (d/c) BLE dressing changes. Apply (elasticized tubular bandage) to BLE in the AM and remove at bedtime. BLE cellulitis healed per wound clinic. discharged from wound clinic. On 7/20/22 the May 2022 TAR was requested for review. On 7/21/22 at 10:30 AM, V1 said that they were unable to locate R8's May TAR. On 7/21/22 at 1:30 PM, V20 (Nurse Practitioner) said that if the staff would have been doing R8's dressing changes like they were ordered from the wound clinic, it would have prevented R8's hospitalization s for cellulitis. V20 said any time a dirty dressing is left in place the risk for infection is increased. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/28/22 at 9:00 AM, V24 (Nurse Practitioner- Wound Clinic) said that if you have a dressing that is left in place for a prolonged period, or do not have a dressing in place to cover a wound, it will increase the introduction of bacteria in the wound subsequently causing an infection. V24 said that R8's dressing changes not being completed as ordered contributed to R8's hospitalization of cellulitis to the bilateral lower extremities. 39744

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F 0689 Level of Harm - 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** 39744 Based on interview, observation and record review the facility failed to initiate fall risk and elopement assessments, and failed to implement and develop progressive and effective interventions for residents with multiple falls for 4 of 7 residents (R20, R7, R16, R290) reviewed for accidents in the sample of 28. This failure resulted in R20 going to the emergency room and receiving 4 staples to a head laceration. Findings include: 1. According to R20 ' s Physician Order Sheet dated 7/1/2022 through 7/31/2022, R20 was admitted to this facility on 8/23/2020 and has the following diagnosis: Dementia, Encephalopathy, Seizures, Diabetes Mellitus type 2, History of falls, Depression, Anxiety, Anemia, Constipation, Gastro Esophageal Reflux Disease, Glaucoma, BPSD (Behavioral and Psychological Symptoms of Dementia), Vitamin D Deficiency, and Shingles Left Eye. R20 ' s most recent MDS (Minimum Data Set) assessment dated [DATE] and completed by V3 (MDSC-Minimum Data Set Coordinator/CPC-Care Plan Coordinator/ LPN-Licensed Practical Nurse/ IP-Infection Preventionist) documents R20 has a BIMS (Brief Interview for Mental Status) score of 03 on a scale up to 15 indicating R20 has severe cognitive impairment. This assessment shows R20 needs limited assistance of 1 staff for bed mobility, transferring, walking, dressing, toileting, all personal hygiene tasks and uses a walker to walk. R20's medical record contained a facility document titled Fall Risk Assessment with room for documenting 4 different assessments. This form has the first assessment section completed with the date listed as 3/10/2022. R20's fall risk score totaled 17 in which a score above 10 is high risk. On 7/20/2022 at 12:30pm, V1 (Administrator/Registered Nurse) presented a list of falls that had occurred at the facility from February 2022 through July 10, 2022. R20 was listed as having falls on these dates: 3/12/22, 3/14/22, 4/9/22, 4/30/22, 5/17/22, 5/31/22, 6/1/22, 6/5/22, 6/7/22, 6/13/22 x2 and 6/16/22. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of R20 ' s care plan for falls lists R20 as having the targeted problem of Resident does not understand mobility limits due to cognition limitations. Risk factors include: Cog (Cognitive) Impairment, use of walker and poor safety awareness. The targeted goal for R20 ' s fall prevention plan is Number of falls per month will be reduced by next review. Interventions to reduce R20 ' s future falls are listed as follows by start date of implementation. Starting 8/18/2021:1. Fall risk assessment quarterly and as needed with change in condition or fall status, 2. review quarterly and a needed during daily care, 3. IDT (Interdisciplinary Team) review and referral to PT (Physical Therapy) and, 4. IDT to review and refer to OT (Occupational Therapy) as needed, 5. Observe for unsteady/unsafe transferring or ambulation and provide assistance, 6. Remind of safety precautions and limitations, 7. IDT review of ADL (Activities of daily living) status and fall potential and report significant findings to the doctor, 8. Assess cognitive deficits and accommodate forgetfulness, 9. Inform doctor of any falls, 10. Encourage resident to use call light and ask for help (8/18/21). Starting 4/18/2022: 11. Encourage resident to sit when signs of fatigue are noted, 12. Monitor for unsteady gait. Starting 5/16/2022: 13. Wear non-slip foot wear, 14. Encourage resident to rest in between wandering behaviors when fatigued. Starting 5/31/2022: 15. Remind to use walker. Starting 6/1/2022: 16. Monitor for fatigue. Starting 6/5/2022: 17. Reduce noise level. Starting 6/7/2022: 18. Obtain basket for walker for items. Starting 6/13/2022: 19. 1:1 when ambulating during moments of fatigue. Starting 6/16/2022: 20. Offer snacks and soda. On 7/20/2022 at 2:30pm, V3 (MDSC-Minimum Data Set Coordinator/CPC-Care Plan Coordinator/ LPN-Licensed Practical Nurse/ IP-Infection Preventionist) was asked what interventions were being implemented to prevent R20 from having future falls. V3 said the staff remind her to use her call light and to use her walker. V3 was asked if any other interventions were in place and V3 said not really, we just have to keep reminding R20. V3 said R20 has seizures and so it is assumed that R20 is having seizure activity and that is causing her falls. V3 said she doesn't consider falls caused by seizure activity as actual fall and R20 has the behavior of putting herself in the floor for attention. V3 said she did not know why falls occurring before 4/18/2022 did not have interventions because she was not appointed to this position until March 2022 and could not speak for the previous care plan coordinator, who no longer worked at the facility. On 7/18/2022 at 9:45am, R20 was observed leaving her bedroom without assistance and entering the restroom down the hall. No staff were observed on R20 ' s hallway or at the nearest nurses station approximately 30 feet away from R20 ' s room. On 7/18/2022 at 1:00pm, R20 again was observed leaving her bedroom without assistance and entering the restroom down the hall. V3 was at the nurse ' s station approximately 30 feet away from R20 during this observation. V3 made no attempt to assist R20 or call for assistance for R20. When R20 finished in the bathroom R20 was observed walking back to her room without staff assistance. On 7/18/2022 at 2:30pm during an interview with V5 (Social Service Director) at the nurse ' s station, R20 was observed ambulating in the hallway by her room with her walker and without staff assistance. No other staff were observed in the hallway, nor at the nurse ' s station. V5 was asked if R20 was supposed to be up walking with her walker by herself in which V5 said, I think it's alright, I know she is supposed to be using her walker. On 7/18/2022 at 3:15pm, R20 was observed with blood in her hair and V3 putting pressure on R20 ' s head. V3 said R20 had fallen and was going to the hospital to be checked out. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R20's Nurses Notes dated 7/18/22 at 15:05 (3:05PM), Was called into another res room notes res lying on R20 (right) side in doorway. Assessment completed. Laceration noted to R side of head in hair-line. 3 cm (centimeters) long. Area cleaned No other injury noted at 15:10 (3:15PM), called (V21, informed of laceration. Red (received) order to send to ER eval & tx (treatment). At 18:00 (6:00PM), Res returned to facilities via wheel chair. Resident escorted to own room. Res has 4 staples in place to laceration. No drng (dressing) noted. A hospital emergency room report dated 7/18/2022 at 16:00 (4:00pm) documented R20 was seen at the local emergency room for complaints of fall injury. On the same evening, this report documented at 17:46 (5:46pm) R20 had wound repair of 2.5 cm (Centimeters) full thickness laceration to right temporal area and linear shaped. Anesthesia: Wound infiltrated with 5 mL (milliliters) of Lidocaine, Wound Prep: simple cleaning with betadine. Skin closed with 4 large staples using staple gun. Final Report sent to the Department dated 7/25/22 regarding R20's fall documents in part, On 7/18/22 at approximately 3:05PM R20 was notes on the floor in the doorway of her bedroom. Subsequently sent to the emergency room for evaluation. Resident's family and MD (Medical Doctor) were notified. An investigation was started per facility protocol. Investigation revealed R20 is impulsive and has impaired cognitive status/poor safety awareness coupled with unsteady gait which lead to her fall. In conclusion, the facility was able to substantiate the alleged fall with injury and determined that R20 lost her balance and fell resulting in the laceration to right forehead On 7/19/2022 at 3:00pm during an interview with V22 (Therapy Director), R20 was again observed ambulating in the hallway in front of her room with her walker and without staff. V22 was asked if R20 was supposed to be walking without assistance and V22 said no R22 is supposed to have someone walking with her. V22 said therapy staff had noticed R20 having several falls over the past few months. V22 said R20's room is a few doors away and across the hall from the therapy room and they notice her frequently walking without staff. V22 said R20 received physical and occupational therapy services for few weeks in June 2022. V22 said R20 did very well and seemed to enjoy working with the therapy staff. V22 said R20 still comes to the therapy room to sit and visit with the staff. On 7/20/2022 at 9:30am, V1 (Administrator/Registered Nurse) said the facility has not been having IDT meeting to discuss falls and develop new fall prevention interventions because until last week she did not know they were supposed to be doing that. V1 said she did not realize R20 ' s care plan had the same intervention implemented several times over and over again and agreed the interventions had not been very effective at reducing R20 ' s falls. V1 said she could see how most of the interventions were not reasonable due to R20 ' s severely impaired cognitive functioning. When asked to review documentation concerning how falls were investigated, root cause analysis determined and new fall interventions were developed, V1 said the facility has not been investigating falls and completing a root cause analysis of the falls because she did not know they were supposed to do that. V1 said all fall investigation paperwork was considered a matter of QA (Quality Assurance) and those documents could not be released or copied. V1 allowed the QA fall paperwork to be reviewed but not copied. None of the documents contained a fall root cause analysis and the section under QA review were blank. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility policy titled Fall Prevention was presented by V1 (Administrator). Under the section labeled Procedure #1 Conduct fall assessments on the day of admission, quarterly and with a change in condition. #2 All staff must observed residents for safety. If residents with a high risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident. #4 Final risk category will be determined by the IDT (Interdisciplinary Team) at their conferences based on: fall score, history of falls, medical conditions which directly impacts equilibrium and/or ambulation and discussion of individual circumstances. #5 Immediately after an resident fall the unit nurse provide care for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. #7 During morning Quality Assurance meetings Monday through Friday, all falls will be discussed and any new interventions will be written on the care plan. 42547 2. The New Admission Information sheet in R7's medical record documents an admitted [DATE]. The Cumulative Diagnosis Log (undated) in R7's medical record document R7's diagnoses include Alzheimer's Dementia, seizures, hypertension (HTN), depression, constipation, vitamin D deficiency, dementia with behavioral disturbance, and anxiety. R7's most recent MDS assessment dated [DATE] documents in section G- Functional Status that R7 requires limited assistance with a one person physical assist with bed mobility, transfers, walking in room and corridor, and locomotion on and off the unit. Section J- Health Conditions is marked No to the question Has the resident had any falls since admission or the prior assessment, whichever is more recent? On 7/20/22 at 11:30 AM, R7 was observed walking in the hallway without assistance. The list of falls that had occurred at the facility from February 2022 through July 10, 2022 provided by V1 documents that R7 had falls on 4/3/22, 4/16/22, and 5/19/22. On 7/20/22 at 3:30 PM, R7's most recent care plan and fall risk assessments were requested for review. The Care Plan (undated) provided for review did not identify R7's risk for falls or any interventions implemented to prevent falls. There was no Fall Risk Assessment provided by the facility for review. The Investigation Report for Falls/ Quality Care Reporting Form for the falls occurring on 4/3/22, 4/16/22, and 5/19/22 were reviewed. The sections documenting the investigation completion date, date of Quality Assurance (QA) review date, summary of events and actions taken, Medical Director signature, Administrator signature, and Director of Nursing signature were all left blank for all 3 falls. The sections documenting Areas of concern identified for further analysis and what new interventions were implemented to prevent further falls? on the Investigation Report form the fall occurring on 4/3/22 and 4/16/22 were left blank. The Investigation Report for the fall on 5/19/22, the question What fall prevention techniques were in use prior to the fall? has a documented response of all requirements of care. The response to the question were the fall prevention techniques in place? was left blank. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/20/22 at 2:45 PM, V10 (Licensed Practical Nurse/ Alzheimer's Unit Coordinator) said that the fall investigation reports are completed by the nurse on duty at the time of the fall. V10 said the nurses assess the resident and the physician and family are notified. V10 said that they have kind of gotten away from the Interdisciplinary Team (IDT) meetings but V10 and V3 (MDS/ Care Plan Coordinator) usually get together and implement a new intervention to add to the care plan. 3. The New Admission Information sheet in R16's medical record documents an admitted [DATE]. The Cumulative Diagnosis Log (undated) in R16's medical record document R16's diagnoses include dementia, Urinary Tract Infection (UTI), falls, diabetes mellitus (DM) type 2, dizziness, cardiomyopathy, hearing loss, hypertension (HTN), hypokalemia, hyponatremia, osteoporosis, atrial fibrillation (A-Fib), history of subdural hematoma, insomnia, and violent outbursts. R16's most recent MDS assessment dated [DATE] documents in section G- Functional Status that R16 requires extensive assistance with a 2 person physical assist with transfers, walking in the room and corridor, and locomotion on and off the unit. Section J-Medical Conditions is marked yes to the question Has the resident had any falls since admission or the prior assessment, whichever is more recent? and documents R16 has had 2 or more falls with no injuries. A Fall Risk assessment dated [DATE] documents a score of 14. The assessment documents that a score of 10 or more equal a high risk for falls. The list of falls that had occurred at the facility from February 2022 through July 10, 2022 provided by V1 documents that R16 had falls on 2/2/22, 2/3/22, 2/4/22, 2/22/22, 3/16/22, 3/19/22, 5/2/22, 5/11/22, 5/23/22, 5/29/22, and 6/21/22. R16's care plan documents a goal under the section Falls of number of falls per month will be reduced by next review with a goal start date of 2/4/22. Interventions documented on the care plan with a start date of 2/4/22 include: fall risk assessment quarterly and as needed with change in condition of fall status, review quarterly and as needed (PRN) resident's Activities of Daily Living (ADL), mobility, cognitive, behavior and overall medical status, IDT review of changes and needs with resident and/ or responsible party during care plan, discuss fall related information to review and revise plan as needed, IDT review of function and referral to Physical Therapy (PT) and Occupational Therapy (OT) as needed, remind resident to lock wheel chair brakes & assist to keep locked and ready for transfer as needed, and attempt to anticipate needs-toileting, hydration, hunger and provide care before resident attempts to fulfill on own. There are no new interventions added to the car plan for falls occurring on 2/22/22, 3/16/22, 3/19/22, and 5/2/22. An intervention added to the care plan dated 5/29/22 documents anticipate toileting needs. The intervention of anticipating toileting needs was already listed as an intervention with a start date of 2/4/22. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Investigation Report for Falls/ Quality Care Reporting Form for R16's falls occurring on 2/2/22, 2/3/22, 2/4/22, 2/22/22, 3/16/22, 3/19/22, 5/2/22, 5/11/22, 5/23/22, 5/29/22, and 6/21/22 were reviewed. The sections documenting the investigation completion date, date of Quality Assurance (QA) review date, summary of events and actions taken, Medical Director signature, Administrator signature, and Director of Nursing signature were all left blank for all falls. The Fall Investigation Report section documenting what intervention was implemented to prevent any further falls? was left blank. The report for the fall occurring on 2/4/22 in the section were fall prevention techniques in place? the response is documented as no Certified Nurse's Aide (CAN) available for COVID hall. On the reports for falls occurring on 3/17/22 and 3/19/22 in the section documenting area of concern identified for further analysis and What new intervention was implemented? were left blank. The reports for falls on 5/2/22 and 5/11/22 in the section documenting What new intervention was implemented? was left blank. There was no Quality of Care Reporting Form available for the fall occurring on 5/29/22. The report for the fall occurring on 6/21/22 in the sections documenting what fall prevention techniques were in use prior to fall and were the fall prevention techniques in place? the responses are both documented as n/a. The section documenting the Area of concern identified for further analysis and what new intervention was implemented? were left blank. 4. A document titled New Admission Information in R290's medical record documents an admitted [DATE]. A document titled Cumulative Diagnosis Log (undated) documents that R290 has a diagnosis of unspecified dementia without behavioral disturbance, insomnia, and anxiety. A Social Service Progress Note dated 7/6/22 documents that R290 is an elopement risk and did try to elope on (R290's) first night here. A Nurse's Note dated 7/17/22 documents that R290 has been yelling over and over I've got to go home A Nurse's Note dated 7/18/22 documents that R290 was exit seeking. On 07/18/22 at 9:30 AM, R290 was observed wandering the halls and in and out of other resident's rooms and yelling where are you Billy? and I have got to get out of here. On 7/18/22 at 2:15 PM, R290 was observed attempting to exit the door of the dementia unit and yelling I've got to go home. R290 was stopped by the staff and did not exit the unit. On 7/20/22 at 12:45 PM, R290 was observed wandering down the hall and into resident's rooms and yelling out where are you? R290's Baseline Care Plan dated 7/6/22 documents under Identified Safety Risks to conduct a high risk elopement assessment and initiate behavior monitoring. On 07/20/22 at 11:45 AM, V3 (Care Plan/ MDS Coordinator/ Infection Preventionist/ Licensed Practical Nurse) said that R290's care plan and comprehensive assessment have not been completed yet. V3 said that the care plan and comprehensive assessment are past due and were due on the July 17th. V3 said that she does not remember doing an elopement or fall risk assessment on R290. The Behavior Tracking Record for R290 dated July 2022 documents a targeted behavior of elopement risk. The Behavior Tracking Record is left blank for first and third shifts for July 2022. Second shift documents behaviors on 7/21/22 with a frequency of 4 times. There is no documentation in the Nurse's Notes on 7/21/22 to provide further detail of R290's behaviors. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	The facility policy titled Elopement/Missing Resident Policy and Procedure (revision date 10/2006) documents It is the policy of (facility) that reasonable precautions are taken to prevent Resident elopement. Reasonable precautions include, but are not limited to: door alarms, wrist alarms and staff intervention.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39744 41610 Based on interview, observation and record review the facility failed to identify severe weight loss of a resident, failed to provide needed interventions to prevent further weight loss, and failed to notify the physician of the severe weight loss for 1 of 6 residents (R6) reviewed for nutrition in the sample of 28. The failure resulted in R6 experiencing a 15.36% (severe) weight loss within 2 months. Findings included: R6's New Admission Information Sheet documents an admitted [DATE]. This sheet documents R6 is a [AGE] year old female with diagnosis including: Alzheimer's Disease, Hypertension, Diverticulitis, Dementia and Hypothyroidism. R6's Minimum Data Set, dated dated dated [DATE] documents in section C (Cognitive Pattern) that R6's Brief Interview of Mental Status score as 02, indicating a severely impaired cognition level. Section G (Functional Status) titled Eating documents that R6 requires supervision/ oversight with encouragement and cueing with set up help only. Section K (Swallowing/ Nutritional Status) documents R6's height as 67 inches and weight as 140 pounds. R6's Physician Order Sheet dated 07/01/22 documents a typed order of: Supplement Orders as House Supplement 60cc two times daily for weight loss dated 08/23/21. The Physician Order Sheet dated 07/01/22 also documents an undated handwritten order of: House Supplement 240 cc four times a day. R6's Physician Order Sheet dated from 07/01/22 to 07/31/22 documents: Dietary order as Regular Diet with a Hydration program of 240 cc extra fluids at meals. R6's Admission Assessment, dated, 08/24/2021, by V16 (Registered Dietician) documents: weight of 134.2 pounds is below an acceptable Body Mass Index range (21.08) - underweight for age. Resident receives a Regular Diet with 240 cc House Supplement four times a day and feeds self. R6's Intake is reported as approximately 75-100% of meals since admission. Diagnosis of Dementia/Alzheimer's/Depression may alter intakes and weights. V16 (Registered Dietician) to follow up as needed. R6's care plan documents: Resident is in need of additional nutrition with a start date of 09/03/21, Resident will consume diet including extra nutrients thru next 90 days with a goal date of 12/02/21, Serve current diet per order - see POS (Physician Order Sheet) with a start date of 09/03/2021, Provide ample time to eat. Encourage resident to eat 75-100% of meals. Record meal intake. Note and report changes in resident usual patterns with a start date of 09/03/2021, Follow recommendations of RD (Registered Dietician)/LDN (Licensed Dietary Nutritionist) of discrepancy of recommendation with resident's preferences of care goals with a start date of 09/03/2021, and offer house supplement per recommendation - see POS for amount and frequency, Observe acceptance and report consistent refusals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R6's most current Dietary Quarterly Assessment is dated 01/30/22 documenting: height 67 inches, current weight 139.3, Average Meal Intake (%) 50-100 % most meals, Feeding Ability/Adaptive Equipment as feeds self with set up. R6's Report of Monthly Weight and Vitals, documents R6's weights as: April 140.1 pounds, May 141.3 pounds, June 122.6 pounds, and July as 119.6 pounds for 2022. R6's paper Chart contained the facility document titled, Dietary Notes which only contained R6's name, no dietary notes are documented. R6's July 2022 Medication Administration Record (MAR) documents, MedPass 240 cc QID (4 times daily). For the month of July a time of 1900 (7:00PM) was listed and only the first and second of the month is marked. For the 1st of the month a percentage is marked but is not legible. There were no other times or dates marked for the rest of July on R6's MAR that MedPass was given to R6. R6's July 2022 MAR does not include and order for MedPass 60cc twice daily. On 07/19/22 at 12:05 PM during lunch, R6 was observed in the dining room with her food tray containing the regular diet, she was seated at the table with the residents receiving eating assistance, she appeared thin and stared more at her food then eating any. No observation of encouragement or cueing was observed by staff. R6's total intake was less than 25%. On 07/20/22 at 12:10 PM during lunch, R6 was observed in the dining room with her food tray containing the regular diet, she was seated at the table with the residents receiving eating assistance, she appeared thin and stared more at her food then eating any. No observation of encouragement or cueing was observed by staff. R6's total intake was less than 25%. On 07/21/22 at 10:15 AM, V16 (Registered Dietician) stated, she would have to consult the notes because she does not remember R6 specifically, however, Everything I charted should be in the file on the Dietary Notes, when V16 was asked about the Dietary Notes being blank, she stated, I can look to see if I have anything else. Throughout the rest of the survey V16 was unable to produce any additional information regarding R6. On 07/21/22 at 1:20 PM, V16 (Registered Dietician) stated, she believes R6's weight for June was documented incorrectly, that is not the weight she has in the AOD program. She believes June's weight is 138 pounds and July's weight is still 119.6. She still currently has approximately a 20 pound weight loss in about 30 days, but it would be in July not June. She has talked today (07/21/22) to V4 (Dietary Manager) about the situation and they will implement interventions, she typically comes at the end of the month and will monitor R6 then. On 07/21/22 at 2:00 PM, V6 (Certified Nurse Aide Scheduler) stated, to weigh the residents they take the resident to the scale, weigh them, write the weight down on a piece of paper and give the piece of paper to the nurse on duty. The nurse then writes the weight in the resident's chart. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 07/21/22 at 2:23 PM, V10 (Licensed Practical Nurse/ Alzheimer's Coordinator) stated, the CNA's will weigh the residents at the beginning of the month and write it down on a piece of paper, they bring that piece of paper to the nurse on duty and the nurse will write the weight in the resident's chart. If a re-weight would have been done, it would be documented by the original weight. V10 stated she does not see where she was ever on weekly weights. V10 stated a copy of the weight will then be given to dietary. V10 stated, she only heard about the AOD program the other day. V10 stated she heard the weights are suppose to be done through the program, but she is not for sure about that, it is new. V10 stated, R6 has lost about 20 pounds between May and June according to her Report of Monthly Weight and Vitals document in her chart, about 13%, that would be considered significant, especially for 30 days. R6 should have had a Dietary Quarterly Assessment done around May since her last one was 01/30/22, R6 has clearly lost weight by looking at her. On 07/21/22 at 2:55 PM, V4 (Dietary Manager) stated, she has different weight than what is documented in the chart. She usually gets the weights together before V16 (Registered Dietician) comes. She usually comes towards the end of the month. She has not completed a Dietary Assessment for R6 yet, she was going to do one after talking to V16 (Registered Dietician) today. According to both sets of weights that she has for R6, R6 has lost approximately 20 pounds in 30 days, that would be considered significant. She does not know why the June weight of 138 pounds is not documented anywhere in R6's chart as opposed to the 122.6 pounds however, the July weight of 119.6 pounds is correct. V4 (Dietary Manager) stated, she did not complete the MD (Medical Doctor) notification of weight change form or contact the physician by the 10th of the month as per the facility policy, her weight had not been discussed with V1 (Administrator) in lack of a Director of Nursing, R6 has not been discussed in a weekly Weight Committee Meeting, and she had not discussed R6 with V16 (Registered Dietician) prior to today when V16 called, but they have an intervention incorporated now. The facility policy titled, Resident Weight Monitoring dated 03/19 documents: 2. Monthly weights are obtained by CNAs or designated staff by the 5th of the month. 3. Monthly weights are entered in the computer in batch by the Dietary Manager, Care Plan Coordinator or designee. 4. The monthly weight report is printed and reviewed by the Dietary Manager and DON by the 8th of the month. 5. If the monthly weight shows a significant change in 30 days (i.e. 5% +/-) the resident will be re-weighed. Re-weights are done by CNA or designated staff. Re-weights are again reviewed, and entered in the computer by the Dietary Manager, Care Plan Coordinator of designee. The monthly weight report is finalized and printed by the 10th of the month. 6. Monthly weights are recorded by designated staff on the Report of Monthly Weight and Vitals form in the Progress Note section of the medical record. 7. If there is an actual significant weight change (i.e. +/- 5% 1 month, +/- 7.5% x 3 months, +/- 10% x 6 months), the resident, POAHC (Power of Attorney Health Care)//family/guardian, physician and dietitian are notified. The physician shall by notified using the MD notification of weight change form. 8. The Food Service Manager and interdisciplinary team review the resident's weights and nutritional status and make recommendations for intervention. 11. Significant weight changes are reviewed in the weekly Weight Committee Meeting. The Weight Committee will also identify any trends of gradual weight loss or gain. Significant changes in weights are documented in the care plan with goals and approaches/interventions listed. 12. Residents who have been determined by the Weight Committee to be at increased risk for weight loss will be put on weekly weights for at least 4 weeks. After four weeks, if weight has stabilized monthly weights will be re-established. 13. All new admissions and re-admissions will be weighed weekly for at least 4 weeks. If weight is stable, weight will be monitored monthly.

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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. 39744 Based on Interview and Record Review the facility failed to have a full time Director of Nursing. This has the potential to affect all 39 residents residing at the facility. Findings Include: On 07/18/22 at 10:30 AM V1(Administrator) stated, they do not currently have a Director of Nursing (DON) working at the facility. She stated in January she was hired as the DON then in April she took over the Administrator position. Resident Council Minutes dated 06/23/22 document: V1 (Administrator) has taken the position as administrator. The facility is liking to hire a new DON. The Resident Census and Conditions of Residents form (CMS-672) dated 7/18/22 documents there are 39 residents living in the facility.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42547 Based on observation, interview, and record review the facility failed to provide the appropriate treatment and services to attain the highest practicable physical, mental, and psychosocial well-being for 3 of 5 residents (R290, R16, and R4) reviewed for dementia care in a sample of 28. Findings include: 1.) A document titled New Admission Information in R290's medical record documents an admitted [DATE]. A document titled Cumulative Diagnosis Log (undated) documents that R290 has a diagnosis of unspecified dementia without behavioral disturbance, insomnia, and anxiety. R290's Physician's Order Sheet (POS) dated July 2022 documents orders for quetiapine (antipsychotic) and escitalopram (antidepressant) dated 7/5/22 and an order for alprazolam (benzodiazepine) dated 7/11/22. R290's Nursing Home History and Physical dated 7/6/22 completed by V20 (Nurse Practitioner) documents staff report (R290) is confused, but pleasant and documents diagnoses of unspecified dementia without behavioral disturbance, insomnia, and anxiety. R290's Nurse's Notes dated 7/11/22 documents that R290 continues to walk around yelling and crying and that V20 was notified of new behaviors and a new order (n.o.) was received. R290's July 2022 POS documents an order dated 7/11/22 for alprazolam (benzodiazepine) 0.5 milligrams (mg) by mouth (PO) every (Q) 12 hours as needed (PRN). R290's Nurse's Note dated 7/13/22 documents that R290 was anxious and very agitated. A Nurse's Note dated 7/14/22 documents that R290 was restless, confused, and anxious. 7/17/22 and 7/20/22 document that R290 was anxious. R290's Social Service Progress Note dated 7/6/22 documents that R290 is an elopement risk and did try to elope on (R290's) first night here. A Nurse's Note dated 7/18/22 documents that R290 was exit seeking. R290's Baseline Care Plan dated 7/6/22 documents under Identified Safety Risks to conduct a high fall risk assessment, high risk elopement assessment, initiate behavior monitoring and that R290 has poor vision, psych med use, yells out, and is disruptive. The Behavior Tracking Record for R290 dated July 2022 documents a targeted behavior of elopement risk. The Behavior Tracking Record is left blank for first and third shifts for July 2022. Second shift documents behaviors on 7/21/22 with a frequency of 4 times. There is no documentation in the Nurse's Notes on 7/21/22 to provide further detail of R290's behaviors. There was no comprehensive person-centered care plan in R290's medical record. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/20/22 at 11:45 AM, V3 (Care Plan/ MDS Coordinator/ Infection Preventionist/ Licensed Practical Nurse) said that R290's care plan and comprehensive assessment have not been completed yet. V3 said that the care plan and comprehensive assessment are past due and were due on the July 17th. V3 said that V3 does not remember doing an elopement or fall risk assessment on R290. On 7/20/22 at 1:30 PM, V10 (Alzheimer's Unit Coordinator/ Licensed Practical Nurse) said that they aren't doing behavior tracking on R290 and said that they used to do Interdisciplinary Team (IDT) meetings to discuss behaviors and falls but that has fallen by the wayside and they don't do them anymore. On 07/18/22 at 9:30 AM, R290 was observed wandering the halls and in and out of other resident's rooms and yelling where are you Billy? and I have got to get out of here. On 7/20/22 at 12:45 PM, R290 was observed wandering down the hall and into resident's rooms and yelling out where are you? 2.) A document titled New Admission Information in R16's medical record documents an admitted [DATE]. A document titled Cumulative Diagnosis Log (undated) documents that R16 has diagnoses including dementia, falls, dizziness, insomnia and violent outbursts. A Minimum Data Set (MDS) assessment dated [DATE] documents in section C-Cognitive Patterns that R16 has a Brief Interview for Mental Status (BIMS) score of 10 indicating that R16 has moderate cognitive impairment. Section E- Behavior documents under the section psychosis that R16 has hallucinations and delusions. The section Behavior Symptoms documents that physical, verbal, and other behavioral symptoms occurred daily. The section Impact on Resident documents yes to did any of the identified symptoms put the resident at a significant risk for physical illness or injury, significantly interfere with the residents care, and significantly interfere with the residents participation in activities or social interactions. R16's July 2022 POS documents orders for lorazepam (benzodiazepine) with an order date of 5/26/22, mirtazapine (antidepressant) with an order date of 4/21/22, and olanzapine (antipsychotic) with an order date of 6/21/22. The Care Plan in R16's medical record documents that R16 has behaviors that others may find disruptive/ socially inappropriate. The section containing specific information about R16's behavior include others may seek reprisal against this Resident, behaviors exhibited, other risk factors that may result in harm to resident, type of reprisal to guard against, those who may seek reprisal, and resident specific information are all left blank. R16's care plan also documents that R16 is known/ has a history of displaying inappropriate behavior and/or resisting care/ services. The section containing resident specific information of specific behavior exhibited, related diagnosis/ condition and risk factors are left blank. Interventions documented with a start date of 2/4/22 include initiate Behavior Monitoring program to attempt to identify patterns, precursors, and causes of behavior and to attempt to understand the meaning of the behavior and review abnormal behaviors with IDT. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/22, Behavior Tracking Records for R16 for May, June, and July 2022 were requested for review. On 7/25/22 at 12:30 PM, V1 (Administrator in Training) said that there were no Behavior tracking Records located for May 2022. The Behavior Tracking Records for June 2022 and July 2022 were provided for review. The Behavior Tracking Record dated June and July 2022 for R16 under the section targeted behavior documents falls, violent outbursts, elopement risk, dizzy. Interventions are documented as 1. redirect 2. continuous visual monitoring when resident is agitated 3. follow resident out of the facility if they get out then redirect back 4. Provide towels to fold to allow feeling of being useful. The Behavior tracking Record for June 2022 contains documentation on 2nd shift for 6/22/22, 6/25/22, 6/26/22, 6/28/22, and 6/29/22. There are no other entries noted for June. There are no entries documented on the Behavior Tracking Record for July 2022 except for one shift on 7/12/22, 7/18/22 and 7/19/22. On 7/12/22 the frequency of behaviors is documented as 4 with interventions of 1-4 being attempted. The specific behaviors occurring are not documented. There is no entry in the Nurse's Notes documenting what behaviors occurred on 7/12/22. On 7/18/22 and 7/19/22 the frequency of behavior is documented as 0. There are no other entries on the Behavior Tracking Record. 3. A document titled New Admission Information in R4's medical record documents an admitted [DATE]. A document titled Cumulative Diagnosis Log (undated) documents that R4 has diagnoses including Alzheimer's disease, dementia with behavior disturbance, repeated falls, major depressive disorder, insomnia, anxiety, and delusional thoughts. R4's July 2022 POS documents that R4 has an order for lorazepam (benzodiazepine) with and order date of 4/8/22, quetiapine (antipsychotic) with an order date of 4/6/22, sertraline (antidepressant) with an order date of 3/16/22, and risperidone (antipsychotic) with an order date of 4/27/22. A Minimum Data Set (MDS) assessment dated [DATE] documents in section C-Cognitive Patterns that R4 has a Brief Interview for Mental Status (BIMS) score of 3 indicating that R4 has severe cognitive impairment. Section E- Behavior documents under the section psychosis that R4 has delusions. The section Behavior Symptoms documents that physical and verbal behavioral symptoms occurred 1 to 3 days. The section Impact on Resident documents yes to did any of the identified symptoms put the resident at a significant risk for physical illness or injury, significantly interfere with the residents care, and significantly interfere with the residents participation in activities or social interactions. R4's Current Care Plan documents in the section titled Psychotropic Drugs that R4 requires the use of psychotropic med to manage mood and/ or behavior issues. A goal (dated 12/15/21) of will respond cooperatively to behavior interventions resulting in maintenance on the lowest therapeutic dose of medication is documented. The section titled Behaviors of R4's Care Plan documents resident known to wander may seek to leave the home. There are no other behaviors documented on R4's care plan. A Nurse's Note dated 4/26/22 documents that R4 was agitated, attempting to exit building, hitting, clawing, kicking. Attempting to bite this writer, that R4 threw plate and drinks on floor, and began yelling at other residents. (R4) then threw glass of H2O (water) on Certified Nurse's Aide (CNA), and R4 continues to hit, bite, kick at staff. A Nurse's Note dated 5/28/22 documents that R4 had an episode of crying. A Nurse's Note dated 6/24/22 documents that R4 was agitated and yelling at staff and residents and throwing objects from the nurse's desk. A Nurse's Note dated 7/2/22 documents that R4 became agitated in the dining room and threw a plate of food and drinks in the floor. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/22, Behavior Tracking Records for May, June, and July 2022 were requested. On 7/25/22 at 12:30 PM, V1 (Administrator in Training) said that R4 did not have any Behavior Tracking Records for May or July 2022. V1 said that V5 (Social Services Director) hasn't been monitoring the resident's behaviors because V5 was unaware that V5 was supposed to. A Behavior Tracking Record for June 2022 was provided for review. The targeted behavior documented on the Behavior Tracking Record is combative, exit seeking. The Behavior Tracking Record for June 2022 has completed documentation on each shift for June 25th through June 30th. The Behavior Tracking Record documents that behaviors occurred on 6/25/22, 6/26/22, 6/28/22, and 6/29/22. There is no documentation on the Behavior Tracking Record or the Nurse's Notes in R4's medical record documenting what type of behaviors R4 had on those dates. The Behavior tracking Record documents that R4 had no behaviors on 6/27/22 and 6/30/22. The rest of the Behavior Tracking Record is left blank.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39744 Based on interview and record review the facility failed to ensure the use of psychotropic medications are only used to treat a specific diagnosed or documented condition, failed to attempt non-pharmacological interventions before beginning psychotropic medications and failed monitor and track targeted behaviors treated by the psychotropic medication for 4 of 6 residents (R4, R16, R27, R290) reviewed for psychotropic medications in the sample of 28. Findings include: 1.) According to R27 ' s Physician ' s Order Sheet dated 7/1/2022 through 7/31/2022, R27 was admitted to this facility on 7/19/2021 and has the following diagnosis: Dementia, Type 2 Diabetes, Hypothyroidism, Hypertention, Osteoporosis, History of Right Leg Fracture, Anemia, Depression, Diabetic Neuropathy, Chronic Renal Failure, General Anxiety Disorder, Hyperlipidemia, Hemorrhoids, Seborrheic Keratosis, and Depressive Disorder. R27 ' s current MDS (Minimum Data Set) assessment dated [DATE] documents R27 as having a BIMS (Brief Interview for Mental Status) score of 03 out of a total of 15 indicating R27 has severe cognitive impairment. This same assessment documents R27 as having delusional thinking, physical and verbal behaviors, refusal of care and significant interference with other residents and their care. R27 ' s Physician ' s order sheet dated 7/1/2022 through 7/31/2022 documents R27 has been receiving the anti-psychotic medication of Risperidone 0.5 mg (Milligrams) by mouth once per day and no indication of what this medication is treating since 1/28/2022. R27 was also ordered the anti-depressant medication of Escitalopram 5mg by mouth once per day for depression since 3/16/2022. R27's care plan documents R27 requires the use of psychotropic medication to manage mood and/or behavior issues. A goal (dated 10/30/2021 of Will respond cooperatively to behavior interventions resulting in maintenance on lowest therapeutic dose of medication is documented. Interventions documented under the Psychotropic Drug section of the care plan are dated 7/19/2021 and include: Administer anti-depressant medication as ordered and Observe for antidepressant side effects of somnolence, insomnia, dry mouth, ect. Additional interventions are dated 8/13/2021 and include: Administer anti-psychotic medication, Observe for antipsychotics side effects of somnolence, insomnia, parkinsonism, dizziness, ect., Educate resident/family to potential risks, benefits and alternatives, Obtain informed consent, IDT (Interdisciplenary Team) meeting with resident quarterly, Attempt gradual dose reduction, during trial reduction attempts, monitor for negative response and report to medical doctor, Assess/record/report drug related Tardive Dyskinesia symptoms and perform AIMS (Abnormal Involuntary Movement Scale) assessment at least every 6 months, Black box warning information for anti-psychotic medication use, Black box warning information for anti-depressant medication use. R27's care plan does not indicate what symptoms or diagnosis is being treated by the anti-psychotic medication. On 7/18/2022 at 2:30pm, V5 (Social Service Director) said the facility staff does not monitor behaviors associated with psychotropic medication usage. V5 said she did not know they were supposed to be doing this. (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/20/2022 at 2:30pm, V3 (MDSC-Minimum Data Set Coordinator/CPC-Care Plan Coordinator/ LPN-Licensed Practical Nurse/ IP-Infection Preventionist) said she was not familiar with the facility's psychotropic medication policy. V3 said she could not locate any targeted behaviors identified on R27's care plan resulting in the need for R27's psychotropic medication use. V3 said they have not been tracking targeted behaviors being treated by psychotropic medication because they did not know they were supposed to be doing that. V3 said V3 said she could not locate an AIMS (Abnormal Involuntary Movement Scale) for R27's psychotropic medication usage. V3 said she could not locate any quarterly Psychotropic Medication Assessments for R27's psychotropic medication usage. On 7/20/2022 at 9:30am, V1 (Administrator/Registered Nurse) said they have not been holding IDT (Interdisciplenary Team) meetings because until last week she did not know they were supposed to be doing them. V1 said she was not familiar with the facility's Psychotropic Medication Policy. V1 said she had only been the facility's administrator for few month and prior to that she was the facility's Director of Nursing, but only for a few months. V1 said she knows they have a lot of improving to do and they are working on it. A facility policy titled Psychotropic Medication Policy (revision date 11/28/2017) under the heading Procedure: #1 attempt to rule out social and environmental factors, #2 Psychotropic medications shall not be prescribed prior to attempted non-pharmacological intervention to decrease behavior. #3 Initiate a Pre-Psychotropic Medication Assessment prior to administration of a newly prescribed psychotropic medication. #4 Initiate a Psychotropic Medication Quarterly Evaluation, #5 Psychotropic medications shall not be prescribed or administered without informed consent, #6 Additional informed consent is not required for dosage reductions, #7 Any resident receiving such medications shall have a psychiatric diagnosis or documented evidence of maladaptive behavior, which can be considered harmful to themselves or others, destructive to property or emotional problems which cause the resident frightful distress, #8 The Behavioral Tracking sheet of the facility will be implemented to ensure behaviors are being monitored, #9 Residents who receive antipsychotic drugs shall receive gradual dose reductions and behavior interventions, #10 Reductions shall be attempted at least twice in one year, unless the physician documents the need to maintain the residents regimen, #11 Nursing administration will meet with the consultant pharmacist on a monthly basis to discuss possible medication reductions, #12 Consultant Pharmacist will request medication reductions as decided on a monthly basis, #13 Licensed Nurses will transcribe new recommendations from the physician, #14 Residents who have had recent dosage reductions will be placed on the 24-hour report sheet and documented on every shift for 30 days for any change of behaviors, #15 Psychotropic medications may be prescribed on an as needed basis in certain situations, #16 The nurse will monitor for side effects, #17 Any resident receiving psychotropic medications will have an AIMS (Abnormal Involuntary Movement Scale) assessment done at a minimum of every 6 months, #18 Any resident receiving any psychotropic medication will have the Psychotropic Medications Assessment done at a minimum of every quarter, #19 Any resident receiving any psychotropic medications will have certain aspects of their use and postneial side effects addressed in the resident's care plan at least quarterly. The care plan will identify target behaviors causing the use of the psychotropic medication. The care plan will address the problem, approaches and goals to address these behaviors. #20 Quarterly documentation will be done on a progress note of any resident that currently receives psychotropic medication. This is to include but no limited to, individual resident responses and/or progress, psychotropic medication assessment, behaviors exhibited, problems or issues which the resident may be having, current medications, recent medication changes and tolerance of medication regimen, #21 The Quality Assurance Committee, on a quarterly basis shall review the overall psychotropic medications reduction program. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42547 2.) A document titled New Admission Information in R4's medical record documents an admitted [DATE]. A document titled Cumulative Diagnosis Log (undated) documents that R4 has diagnoses including Alzheimer's disease, dementia with behavior disturbance, repeated falls, major depressive disorder, insomnia, anxiety, and delusional thoughts. R4's July 2022 Physician's Order Sheet (POS) documents that R4 has an order for lorazepam (benzodiazepine) with and order date of 4/8/22, quetiapine (antipsychotic) with an order date of 4/6/22, sertraline (antidepressant) with an order date of 3/16/22, and risperidone (antipsychotic) with an order date of 4/27/22. R4's Care Plan documents in the section titled Psychotropic Drugs that R4 requires the use of psychotropic med to manage mood and/ or behavior issues. A goal (dated 12/15/21) of will respond cooperatively to behavior interventions resulting in maintenance on the lowest therapeutic dose of medication is documented. Interventions documented under the Psychotropic Drugs section of the care plan are dated 6/17/21 include administration of antianxiety, antipsychotic, and antidepressant medications as prescribed and monitor for side effects. There is no documentation in R4's care plan documenting the rationale for use or monitoring of a benzodiazepine. The section titled Behaviors of R4's Care Plan documents resident known to wander may seek to leave the home. There are no behaviors documented on R4's care plan to include non-pharmacological interventions to prevent behaviors treated with psychotropic drugs. On 7/21/22, Behavior Tracking Records for May, June, and July 2022 were requested. On 7/25/22 at 12:30 PM, V1 (Administrator in Training) said that R4 did not have any Behavior Tracking Records for May or July 2022. V1 said that they haven't been doing any specific behavior tracking for targeted behaviors like anxiety and depression that are treated with psychotropic medications. V1 said that V5 (Social Services Director) hasn't been monitoring the resident's behaviors or effects of the psychotropic medication because V5 was unaware that V5 was supposed to. A Behavior Tracking Record for June 2022 was provided for review. The targeted behavior documented on the Behavior Tracking Record is combative, exit seeking. The Behavior Tracking Record for has completed documentation on each shift for June 25th through June 30th. The rest of the Behavior Tracking Record is blank. 3.) A document titled New Admission Information in R290's medical record documents an admitted [DATE]. A document titled Cumulative Diagnosis Log (undated) documents that R290 has a diagnosis of unspecified dementia without behavioral disturbance, insomnia, and anxiety. R290's Physician's Order Sheet (POS) dated July 2022 documents orders for quetiapine (antipsychotic) and escitalopram (antidepressant) dated 7/5/22 and an order for alprazolam (benzodiazepine) dated 7/11/22. R290's Nursing Home History and Physical dated 7/6/22 completed by V20 (Nurse Practitioner) documents that R290 is staff report (R290) is confused, but pleasant and documents diagnoses of unspecified dementia without behavioral disturbance, insomnia, and anxiety. R290's Nurse's Notes dated 7/11/22 documents that R290 continues to walk around yelling and crying and that V20 (Nurse Practitioner) was notified of new behaviors and a new order (n.o.) was received. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R290's July 2022 POS documents an order dated 7/11/22 for alprazolam (benzodiazepine) 0.5 milligrams (mg) by mouth (PO) every (Q) 12 hours as needed (PRN). R290's Nurse's Note dated 7/13/22 documents that R290 was anxious and very agitated. A Nurse's Note dated 7/14/22 documents that R290 was restless, confused, and anxious. 7/17/22 and 7/20/22 document that R290 was anxious. A Baseline Care Plan dated 7/6/22 documents under Identified Safety Risks to initiate behavior monitoring and that R290 uses psych meds, yells out, and is disruptive. There are no Behavior Tracking Records available for R290 for targeted symptoms for the use of quetiapine, escitalopram, and alprazolam or the use of non-pharmacological interventions for R290's behaviors. There is no comprehensive person-centered care plan in R290's medical record. On 07/20/22 at 11:45 AM, V3 (Care Plan/ MDS Coordinator) said that R290's care plan and comprehensive assessment have not been completed yet. V3 said that the care plan and comprehensive assessment are past due and were due on the July 17th. On 7/20/22 at 1:30 PM, V10 (Alzheimer's Unit Coordinator/ Licensed Practical Nurse) said that they aren't doing behavior tracking on R290 and said that they used to do Interdisciplinary Team (IDT) meetings to discuss behaviors but that has fallen by the wayside and they don't do them anymore. The Behavior Tracking record for R290 dated July 2022 documents a targeted behavior of elopement risk. There are no Behavior Tracking Records for R290 for the targeted behaviors treated with psychotropic medication, effects of medication, or non-pharmacological interventions utilized. On 7/25/22 at 1:30 PM, V20 (Nurse Practitioner) said that the facility staff need to be documenting the specific behaviors the resident is presenting, the use of non-pharmacological interventions, and the residents response to the interventions. 4.) A document titled New Admission Information in R16's medical record documents an admitted [DATE]. A document titled Cumulative Diagnosis Log (undated) documents that R16 has diagnoses including dementia, falls, dizziness, insomnia and violent outbursts. A Minimum Data Set (MDS) assessment dated [DATE] documents in section C-Cognitive Patterns that R16 has a Brief Interview for Mental Status (BIMS) score of 10 indicating that R16 has moderate cognitive impairment. Section E- Behavior documents under the section psychosis that R16 has hallucinations and delusions. The section Behavior Symptoms documents that physical, verbal, and other behavioral symptoms occurred daily. The section Impact on Resident documents yes to did any of the identified symptoms put the resident at a significant risk for physical illness or injury, significantly interfere with the residents care, and significantly interfere with the residents participation in activities or social interactions. R16's July 2022 POS documents orders for lorazepam (benzodiazepine) with an order date of 5/26/22, mirtazapine (antidepressant) with an order date of 4/21/22, and olanzapine (antipsychotic) with an order date of 6/21/22. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan in R16's medical record documents that R16 has behaviors that others may find disruptive/ socially inappropriate. The section containing specific information about R16's behavior include others may seek reprisal against this Resident, behaviors exhibited, other risk factors that may result in harm to resident, type of reprisal to guard against, those who may seek reprisal, and resident specific information are all left blank. R16's care plan also documents that R16 is known/ has a history of displaying inappropriate behavior and/or resisting care/ services. The section containing resident specific information of specific behavior exhibited, related diagnosis/ condition and risk factors are left blank. Interventions documented with a start date of 2/4/22 include initiate Behavior Monitoring program to attempt to identify patterns, precursors, and causes of behavior and to attempt to understand the meaning of the behavior and review abnormal behaviors with IDT. On 7/21/22, Behavior Tracking Records for R16 for May, June, and July 2022 were requested for review. On 7/25/22 at 12:30 PM, V1 (Administrator in Training) said that there were no Behavior tracking Records located for May 2022. The Behavior Tracking Records for June 2022 and July 2022 were provided for review. The Behavior Tracking Record dated June and July 2022 for R16 under the section targeted behavior documents falls, violent outbursts, elopement risk, dizzy. Interventions are documented as 1. redirect 2. continuous visual monitoring when resident is agitated 3. follow resident out of the facility if they get out then redirect back 4. Provide towels to fold to allow feeling of being useful. The Behavior tracking Record for June 2022 contains documentation on 2nd shift for 6/22/22, 6/25/22, 6/26/22, 6/28/22, and 6/29/22. There are no other entries noted for June. The Behavior Tracking Record for July 2022 contains entries on 7/12/22, 7/18/22 and 7/19/22. On 7/12/22 the frequency of behaviors is documented as 4 with interventions of 1-4 being attempted. The specific behaviors occurring are not documented. There is no entry in the Nurse's Notes documenting what behaviors occurred on 7/12/22. On 7/18/22 and 7/19/22 the frequency of behavior is documented as 0. There are no other entries on the Behavior Tracking Record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 42547 Based on observation, interview, and record review, the facility failed to have a medication error rate of less than 5% for 5 of 7 residents (R8, R14, R35, R15, and R35) reviewed for medication administration in a sample of 28. Findings include: 1.) R8's July 2022 Physician's Order Sheet (POS) documents an order dated 7/9/20 for Vitamin D3 25 micrograms (mcg) take one tablet by mouth once daily with an administration time of 0700 (7:00 AM). R8's July 2022 Medication Administration Record (MAR) documents the order for Vitamin D3 as written on the POS. On 7/19/22 at 11:15 AM, the order for Vitamin D3 was initialed as being administered for 7/19/22 at 0700. V7 (Licensed Practical Nurse) prepared the medications ordered to be at administered at 1100 (11:00 AM) and placed them in a medicine cup. V7 was observed placing a Vitamin D3 25 mcg tablet in the medicine cup to be administered with the other medications ordered to be administered at 1100 (11:00 AM). V7 stated that she had already initialed the medication on the MAR and was pretty sure I forgot to give it this morning. V7 said I am going to go ahead and give it. It's not technically a med error if she gets it again because it is just a vitamin. V7 then administered the medication to R8, including the Vitamin D3 tablet. 2.) R35's July 2022 POS documents an order dated 11/11/20 for multivitamin/ minerals tab with instructions to take one tablet by mouth once daily with an administration time of 1100 (11:00 AM). R35's July 2022 MAR documents the same order as documented on the POS. On 7/19/22 at 11:35 AM, V7 prepared R35's medications with administration time documented at 1100 (11:00 AM) and placed the medications in a medication cup with the exception of the multivitamin/ mineral tablet. V7 administered the medications in the medicine cup to R35. After administering the medication to R35, V7 said that the multivitamin tablets are stored in a bottle in the top drawer of the medication cart and I guess I forgot to give it to her and said you should have told me before now that I forgot it. 3.) On 7/19/22 at 11:45 AM, R14 was in the dining room and reported to V7 that R14 was hurting. V7 said that R14 had already had a pain pill this morning and is not due for another pain pill yet. V7 said I will just give her some (Acetaminophen) for now. R14's POS for July 2022 documents and order for acetaminophen 500 milligram (mg) tablet, take 2 tablets by mouth every 12 hours, do not exceed 4 grams of APAP (Acetaminophen) in 24 hours with administration times of 0700 (7:00 AM) and 1900 (7:00 PM). V7 prepared R14's medication ordered for 11:00 AM and included two 500 mg tablets of Acetaminophen in the medication to be administered to R14. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V7 initialed 2 of the medications on the MAR that were ordered for 11:00 AM that were placed in the medication cup prior to the administration of the medication. V7 was asked to locate the order for Acetaminophen on the MAR prior to administering the medications. V7 stated I know she has an order for it because all residents have an order for (Acetaminophen). V7 then located the order for Acetaminophen on the MAR and stated I guess she can't have any because I already gave it to (R14) this morning at 7. The order for the acetaminophen was initialed as already being administered on 7/19/22 at 7:00 AM on the MAR. V7 then removed the Acetaminophen tablets form the medication cup and threw the tablets in the trash. 4.) The Cumulative Diagnosis Log (undated) in R15's medical record documents that R15 has a diagnosis of orthostatic hypotension . R15's July 2022 MAR and POS documents an order dated 2/9/22 for Midodrine HCl 5 mg tablet, take one tablet by mouth 3 times daily- hold if systolic blood pressure (BP) is above 160. The July 2022 MAR and POS also documents an order dated 11/4/21 for blood pressure and pulse three times a day (TID) related to (r/t) Midodrine prescription (Rx)-hold if higher than 160. On 7/19/22 at 11:55 AM, V7 administered Midodrine 5mg as ordered to R15. V7 was not observed checking R15's blood pressure or pulse prior to administering the Midodrine. There is one blood pressure recorded on the MAR at 0700 (7:00 AM) of 140/81 and no pulse recorded on 7/19/22. The Midodrine is initialed as being given at 0700 (7:00 AM) and 1100 (11:00 AM). 5.) R18's POS for July 2022 documents and order dated 11/24/21 for Risperidone 1mg tablet, take 1/2 tablet (0.5 mg) by mouth in the morning with an administration time of 1100 (11:00 AM) and order dated 11/24/21 for Risperidone 1 mg tablet, take 1 tablet by mouth in the evening with an administration time of hour of sleep (HS). On 7/19/22 at 12:10 PM, V7 prepared R18's medications with administration times of 1100 (11:00 AM) as documented on the MAR. V7 said that R18 had 2 cards for Risperdal in the med cart. V7 removed a Risperdal 1 mg tablet and placed it in the cup to be administered to R18. V7 stated does that look right to you? V7 reviewed R18's orders as documented on the MAR and said that R18 should have only got a 1/2 of a 1mg tablet (0.5 mg) of Risperdal. V7 removed the 1 mg tablet from the medicine cup and replaced it with the 1 mg 1/2 tablet (0.5 mg) as ordered. V7 said I'm glad you caught that. That extra 1/2 of a milligram wouldn't have made much of a difference anyway. The facility policy titled Medication Administration (undated) documents under the section Procedure in step 6 Medications must be identified by using the seven (7) rights of administration: right resident, right drug, right dose, right consistency, right time, right route, right documentation and in step 8 When preparing medication for administration, check the label of the drug container at minimum three times for safety and accuracy: when reaching for the medication, immediately before pouring or punching medication, when returning the container to its storage location.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 42547 Based on observation, interview, and record review the facility failed to keep residents free of significant medication errors for 1 of 7 residents (R15) reviewed for medication administration in a sample of 28. Findings include: The Cumulative Diagnosis Log (undated) in R15's medical record documents that R15 has a diagnosis of orthostatic hypotension. R15's July 2022 Medication Administration Record (MAR) and Physician's Order Sheet (POS) documents an order dated 2/9/22 for Midodrine HCl (vasoconstrictor) 5 mg tablet, take one tablet by mouth 3 times daily-hold if systolic blood pressure (BP) is above 160. The July 2022 MAR and POS also documents an order dated 11/4/21 for blood pressure and pulse three times a day (TID) related to (r/t) Midodrine prescription (Rx)-hold if higher than 160. On 7/19/22 at 11:55 AM, V7 (Licensed Practical Nurse) administered Midodrine 5mg as ordered to R15. V7 was not observed checking R15's blood pressure or pulse prior to administering the Midodrine. There is one blood pressure recorded on the MAR at 0700 (7:00 AM) of 140/81 and no pulse recorded on 7/19/22. The Midodrine is initialed as being given at 0700 (7:00 AM) and 1100 (11:00 AM). On 7/19/22 at 2:45 PM, V1 (Administrator) said that blood pressure checks are documented on the daily charting sheets and are kept at the nurse's station. V1 said that if a resident is ordered a blood pressure check three times a day it would be documented on the daily charting sheets. On 7/19/22 at 3:00 PM, V10 (Alzheimer's Coordinator/ Licensed Practical Nurse) said that the residents vital signs are checked daily. V10 said that R15's vital signs are taken daily and are done on night shift, V10 said that if you are looking for a blood pressure and pulse done three times a day then you aren't going to find it unless it is on the MAR. If it isn't there, it wasn't done or they didn't document it. On 7/21/22 at 1:30 PM, V1 said that they were unable to locate any other blood pressure or pulse recordings other than what is documented on the MAR. V1 said that they were not checking R15's blood pressure and pulse three times a day prior to the administration of the Midodrine. The May and June 2022 POS and MAR's were reviewed and contain the same orders for the Midodrine and BP checks as written on the July 2022 POS and MAR. The May 2022 MAR documents 78 BP check and 2 pulse check recordings out of 93 (31 days- 3 times per day) opportunities of ordered BP and pulse checks. The June 2022 MAR documents 61 BP check and 6 pulse check recordings out of 90 (30 days- three times per day) opportunities for ordered BP and pulse checks. The July 2022 MAR documents 34 BP check and no pulse check recordings out of 54 (18 days- 3 times per day) opportunities of ordered BP and pulse checks. The Midodrine prescription was initialed as administered 3 times per day as ordered for May, June, and July except for 3 times (6/13/22, 7/3/22, and 7/4/22) in which no initials were documented and 1 time (6/28/22 at 9:00 PM) in which it is documented that the Midodrine Rx was held and not administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/22 at 1:30 PM, V20 (Nurse Practitioner) said that she would expect R15's blood pressure and pulse be checked three times a day prior to the administration of the Midodrine. V20 said that R15 has not had any negative outcomes or hospitalization s as a result of taking the Midodrine without proper blood pressure monitoring. The Food and Drug Administration (https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/019815s010lbl.pdf) label data documents under the section Warnings that It is essential to monitor supine and sitting blood pressures in patients maintained on (Midodrine Hydrochloride). Uncontrolled hypertension increases the risk of cardiovascular events, particularly stroke.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on observation, interview and record review the facility failed to follow the portion sizes documented on the approved menu for 7 of 7 residents (R5, R&, R9, R12, R25, R32, and R39) reviewed for receiving a mechanically altered diet in the sample of 28. Findings Include: The Menu dated Week 3, Tuesday, documents at noon the Mechanical Soft diet should receive 3 ounces of Ground Roast Turkey with gravy and the Pureed Diet should receive a #8 scoop (4 ounces) of Pureed Roast Turkey. On 07/19/22 at 12:05 PM the #16 scoop (2 ounces) was used to serve the Mechanical Soft Roast Turkey and the #20 scoop (1.6 ounces) was used to serve the Pureed Roast Turkey. On 07/19/22 at 1:15 PM, V4 (Dietary Supervisor) stated V8 (Cook) used the wrong size scoops during lunch and the wrong portion sizes were served to the residents receiving the Mechanical Soft Diets and the Pureed Diets, the kitchen staff needs to be more careful. The Menu dated Week 3, Wednesday, documents at noon the Mechanical Soft diet should receive 6 ounces of Ground Beef and Noodles and the Pureed Diet should receive a #6 scoop (5.33 ounces) of Pureed Beef and Noodles. On 07/20/22 at 12:20 PM the #16 scoop (2 ounces) of Mechanical Soft Ground Beef and Noodles were served to the residents receiving the Mechanical Soft Diet and the #16 scoop (2 ounces) of Pureed Beef and Noodles were served to the residents receiving the Pureed Diet. On 07/20/22 at 1:10 PM, V4 (Dietary Supervisor) stated V8 (Cook) used the wrong size scoops during lunch and the wrong portion sizes were served to the residents receiving the Mechanical Soft Diets and the Pureed Diets, she talked to V8 (Cook) yesterday but she just did not pay attention again today to the correct scoop sizes. R5's New Admission Information sheet Documents an admitted [DATE] with diagnosis including: Dementia with [NAME] Bodies, Alzheimer's Disease, Seizure disorder, Type II Diabetes Mellitus, and Hyperlipidemia. R5's Physician Order Sheet dated 07/01/22 documents Dietary Orders as: Puree Diet with a date of 04/02/21. R5's Minimum Data Set, dated dated dated [DATE] Section C documents; Cognitive test should not be performed and refers to Section C1000 which documents: Cognitive skills for Daily Decision Making is Severely Impaired. R7's New Admission Information sheet Documents an admitted [DATE] with diagnosis including: Dementia, Seizure disorder, Depression and Anxiety. R7's Physician Order Sheet dated 07/01/22 documents Dietary Orders as: Mechanical Soft Diet with Puree Meats with a date of 04/21/17. R7's Minimum Data Set, dated dated dated [DATE] Section C documents; Cognitive test should not be performed and refers to Section C1000 which documents: Cognitive skills for Daily Decision Making is Severely Impaired. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's New Admission Information sheet Documents an admitted [DATE] with diagnosis including: Dementia, Alzheimer Disease, and BiPolar Disorder. R9's Physician Order Sheet dated 07/01/22 documents Dietary Orders as: Mechanical Soft Diet with a date of 05/28/20. R9's Minimum Data Set, dated dated dated [DATE] Section C documents; Cognitive test should not be performed and refers to Section C1000 which documents: Cognitive skills for Daily Decision Making is Severely Impaired. R12's New Admission Information sheet Documents an admitted [DATE] with diagnosis including: Dementia, Diabetes Mellitus, and Hyperlipidemia. R12's Physician Order Sheet dated 07/01/22 documents Dietary Orders as: Puree Meats Diet with a date of 03/07/19. R12's Minimum Data Set, dated dated dated [DATE] Section C documents; Cognitive test should not be performed and refers to Section C1000 which documents: Cognitive skills for Daily Decision Making is Severely Impaired. R25's New Admission Information sheet Documents an admitted [DATE] with diagnosis including: Dementia, Alzheimer Disease, and Hypertension. R25's Physician Order Sheet dated 07/01/22 documents Dietary Orders as: Pureed Diet with a date of 03/30/22. R25's Minimum Data Set, dated dated dated [DATE] Section C documents; Cognitive test should not be performed and refers to Section C1000 which documents: Cognitive skills for Daily Decision Making is Severely Impaired. R32's New Admission Information sheet documents at admitted [DATE] with diagnosis including: Dementia, Stroke, and Dysphagia. R32's Physician Order Sheet dated 07/01/22 documents Dietary Orders as: Mechanical Soft Diet with a date of 05/20/22. R32's Minimum Data Set, dated dated dated [DATE] Section C documents a score of 00 denoting Cognition level is Severely Impaired. R39's New Admission Information sheet Documents an admitted [DATE] with diagnosis including: Dementia, Alzheimer Disease, Anemia, Syncope, Hypertension, and Chronic Kidney Disease stage 3. R39's Physician Order Sheet dated 07/01/22 documents Dietary Orders as: Pureed Diet with a date of 02/17/21. R39's Minimum Data Set, dated dated dated [DATE] Section C documents; Cognitive test should not be performed and refers to Section C1000 which documents: Cognitive skills for Daily Decision Making is Severely Impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 41610 Based on interview and record review the facility failed to conduct Quality Assurance Meetings for the last seven months. This has the potential to affect all 39 residents residing at the facility. Findings Include: On 07/20/22 at 1:40 PM, V1(Administrator) stated, they have not had an actual Quality Assurance Meeting since she has worked at the facility. They have had daily meetings but not a meeting that includes the complete Quality Assurance Committee. They should have had the quarterly meetings. On 07/21/22 at 12:45 PM, V2 (Regional Administrator Director) stated they have not had a true QAA meeting that she is aware of. V2 stated she took over this building around April, they should be having them every three months. On 07/21/22 at 1:15 AM, V2 stated, she can not find any attendance sheets from any Quality Assurance meetings for the last seven months. The facility could not provide any documenting of any Quality Assurance Meetings attendance sheets. The Resident Census and Conditions of Residents form (CMS-672) dated 7/18/22 documents there are 39 residents living in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/28/2022

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on Interview and record review the facility failed to provide Influenza and Pneumococcal Immunizations for 2 of 5 (R27 and R12) reviewed for Pneumococcal Immunizations in the sample of 28. Findings Include: 1. R27's current medical record contained a document titled, Immunization Record in which the last information documented on the Pneumococcal section is the Pneumococcal PVC 13 with a date given as 03/10/20 with no documentation in the Pneumococcal PPSV 23 section. The Facility Document titled, Consultation Report documents (R27) is a [AGE] years of age or older, received PCV13 on 03/10/20 and the medical record does not include documentation of PPSV23 vaccination. Recommendation: Unless clinically contraindicated, please vaccinate with one dose of PPSV23 (administer 0.5 ml intramuscularly or subcutaneously). Physician's Response: I accept the recommendation(s) above, please implement as written statement is checked. This document is then signed by V20 (Nurse Practitioner) and dated 04/19/22. R27's Nurse's Notes document on 04/19/22 at 1407 (2:07 PM) Power of Attorney (POA) returned call to facility. This nurse asked for permission to administer the PPSV23 vaccine. POA gave permission. R27's Nurse's Notes document on 04/19/22 at 1458 (2:58 PM) New Order per pharmacy recommendation signed by V20 to vaccinate with one dose of PPSV23. R27's Medication Record documents: Medication: PPSV23 with a date of 04/19/22 with no documentation of the vaccination given. 2. R12's Immunization Record does not document and Influenza or Pneumococcal vaccinations given for 2021 or 2022. R12's most current Resident Influenza & Pneumonia Vaccine Consent is dated 09/23/20. On 07/21/22 at 6:20 PM, V23 (Family) stated, she gave consent for R12 to receive Influenza and & Pneumococcal vaccinations again for 2021. On 07/20/22 at 1:20 PM, V1 (Administrator) stated, all documentation of R27's immunizations would be documented on the Immunization Record and if it was given it would be documented on the Medication Record and R12 should have a Resident Influenza & Pneumonia Vaccine Consent Form in her medical record. The Facility policy titled, Immunization of Residents dated 09/17 states: 5. Offer the PCV13, PCV15, PCV20 or PPSV 23 as indicated utilizing the Pneumonia Vaccine Timing Guidelines, unless contraindicated. Offer the influenza immunization annually from October 1st thru March 31st (with physician order) or as directed by the Medical Director. 9. Document immunization on the resident's Medication Administration Record and on the resident's Immunization Record.