STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watseka Rehab & Hlth Care Ctr	715 East Raymond Road Watseka, IL 60970

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 40385 Based on observation, interview, and record review the facility failed to notify the resident's physician and family of a newly identified wound, and failed to notify the physician of missed doses of medications and a change in condition for four (R12, R9, R10, R7) of four residents reviewed for physician notification in the sample list of 14. Findings include: 1.) On 8/3/22 at 2:12 PM V21 Certified Nursing Assistant (CNA) and V3 Assistant Director of Nursing (ADON) cleansed R12's abdominal folds. There was a linear, pink, open wound to R12's left abdominal fold. V3 applied a barrier cream to the wound. V3 stated R12's wound was identified on 8/2/22 during R12's bedbath. There is no documentation in R12's medical record that R12's Physician (V15) or family was notified of R12's wound on 8/2/22. On 8/4/22 at 10:35 AM V2 DON stated: When a wound is identified, the physician and family should be notified and documented in a nursing note. V2 stated documentation is an area that is lacking. If it is not documented then we can't back up that it was done. 2.) R9's June 2022 Physician's Orders document orders for Lisinopril 20 mg daily at 8:00 AM and Novolog insulin per sliding scale based on blood sugar results at 7:30 AM, 11:30 AM, 4:30 PM, and 8:30 PM. On 8/3/22 at 10:34 AM V10 Licensed Practical Nurse prepared and administered R9's morning medications. V10 did not administer Lisinopril. V10 returned to R9's room at 10:50 AM to obtain R9's blood sugar of 294. V10 stated this will be the noon blood sugar check, since V10 did not complete R9's morning blood sugar check. V10 did not administer Novolog 8 units as ordered per the sliding scale. On 8/3/22 at 11:05 AM V10 stated all of R9's morning medications, excluding Lisinopril and Novolog, were administered. On 8/3/22 at 2:20 PM V10 stated R9's noon dose of Novolog has not been administered since the medication has not arrived yet from the pharmacy. V10 stated V10 has not done any follow up regarding R9's Lisinopril that was not available or administered. There is no documentation in R9's medical record that R9's Physician (V19) was notified of the missed doses of Novolog and Lisinopril on 8/3/22. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) R10's August 2022 Physician's Orders document an order for Losartan Potassium 50 mg daily at 8:00 AM. On 8/3/22 at 11:20 AM V9 Registered Nurse administered R10's morning medications, and did not administer Losartan Potassium. On 8/3/22 at 11:56 AM V9 stated there was no supply of the Losartan Potassium, and it would need to be ordered from the pharmacy. There is no documentation in R10's medical record that R10's Physician (V19) was notified of the missed dose of Losartan Potassium. 4.) On 8/3/22 at 9:11 AM R7 was sitting in a recliner in R7's room. R7's bilateral lower extremities were in a dependent position and were edematous. R7 stated R7 was unable to wear R7's slippers due to R7's edema. R7's August 2022 Physician's Orders document R7 has a diagnosis of Congestive Heart Failure. R7's Admission Physician's Orders dated 7/13/22 documents orders for Eliquis (anticoagulant) 5 mg by mouth twice daily, Diltiazem Hydrochloride (antihypertensive) 180 mg by mouth daily, Furosemide (diuretic) 40 mg by mouth twice daily, and Lisinopril 30 mg by mouth daily. R7's July 2022 Medication Administration Record (MAR) does not document the following medications were administered as ordered: Furosemide on 7/13, 7/14, and the morning of 7/15/22. Eliquis at 8:00 AM on 7/14 and 7/15/22. Diltiazem and Lisinopril on 7/14 and 7/15/22. R7's Nursing Notes document R7 had dependent edema first recorded on 7/18/22. There is no documentation in R7's medical record that V15 Physician was notified of R7's edema or missed doses of Furosemide, Eliquis, Diltiazem and Lisinopril. On 8/4/22 at 11:40 AM V15 Physician stated that V15 was not aware that R7 had missed doses of medications or that R7 had edema to bilateral lower extremities. On 8/4/22 at 8:40 AM V2 DON reviewed R7's July 2022 MAR and confirmed there is no documentation that Eliquis, Diltiazem, Furosemide, and Lisinopril were administered as ordered on the dates listed. V2 reviewed R7's nursing notes and confirmed there is no documentation that R7 had edema prior to 7/18/22, and no documentation that R7's edema and missed doses of medication were reported to R7's Physician. V2 stated V2 would expect the physician to be notified of R7's edema. On 8/4/22 at 10:35 AM V2 stated the physician should be notified of missed doses of medications and documented in a nursing note. V2 confirmed there was no documentation that the physician was notified of R9's and R10's missed doses of medications on 8/3/22. The facility's Medication Administration policy dated as revised 11/18/17 documents to notify the physician if a scheduled dose of medication was not administered or available. The facility's Notification for Change in Resident Condition or Status dated as revised on 12/7/17 documents the nurse will notify the resident's physician of changes in a resident's physical/emotional/mental condition and when pressure ulcers or stasis ulcers are identified. This policy documents a resident's representative should be notified when there is a significant change in the resident's physical/mental/psychological condition.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40385 Based on interview and record review the facility failed to protect a resident (R4) from physical abuse by (R3). R3 and R4 are two of six residents reviewed for abuse in the sample list of 14. Findings include: The facility's Final Report dated 7/15/22 documents there was an allegation of a physical altercation between R3 and R4. V17 Housekeeper's written interview dated 7/12/22 at 9:30 AM documents R3 put R3's foot out and try to block R4 from going past R3, R4 attempted to go around R3, and R3 grabbed R4's arm. R4's written interview statement dated 7/12/22 at 10:00 AM documents R4 was trying to get in line to go smoke, R3 told R4 to get out of R3's way, R3 grabbed R4's arm and pulled R4's arm and pulled R4 back. R4's Orthopedic Progress Note dated 6/20/22 documents R4 has a left proximal humerus/humeral shaft fracture and to continue with nonweight bearing to the left upper extremity. On 8/2/22 at 9:43 AM R4 stated: A few weeks ago R3 grabbed my left arm, the one that I broke. R3 wasn't joking around. R4 had bumped R3's foot when R4 was trying to go around R3, and that upset R3. R3 used force to grab and pull my arm, it hurt my collarbone. On 8/2/22 at 10:31 AM V17 Housekeeper stated: R3 and R4's incident in July occurred near the nurse's station. V17 witnessed R4 attempt to walk past R3 in the smoking line, and R3 told R4 to wait. R3 grabbed R4's arm in an aggressive manor, and not in a playful nature. R3 and R4 were separated immediately. The facility's Abuse Prevention Program revised 11/28/2016 documents: The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to implement its abuse prevention policy by failing to assess a resident after a resident to resident altercation and by failing to report abuse allegations to residents' physicians and representative for four (R1, R2, R3, R4) of six residents reviewed for resident to resident abuse in the sample list of 14. Findings include: The facility's Abuse Prevention Program with a revision date of 11/28/16 documents the following: The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, other abnormalities, or injuries of unknown origin as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee. If the resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted. The administrator or designee will also inform the resident or resident's representative of the report of an occurrence of potential mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property and that an investigation is being conducted. For allegations of possible physical abuse, do a full body exam, particularly in areas of resident complaint. Check range of motion. Consult with physician as to the need for further diagnosis, examination or x-rays. 1.) The facility's Final Report dated 7/15/22 documents there was an allegation of a physical altercation between R3 and R4. V17 Housekeeper's written interview dated 7/12/22 at 9:30 AM documents R3 put R3's foot out and try to block R4 from going past R3, R4 attempted to go around R3, and R3 grabbed R4's arm. R4's written interview statement dated 7/12/22 at 10:00 AM documents R4 was trying to get in line to go smoke, R3 told R4 to get out of R3's way, R3 grabbed R4's arm and pulled R4's arm and pulled R4 back. R4's Orthopedic Progress Note dated 6/20/22 documents R4 has a left proximal humerus/humeral shaft fracture and to continue with nonweight bearing to the left upper extremity. There is no documentation in R4's medical record that R4 was assessed for injury/range of motion after the altercation with R3 on 7/12/22. There is no documentation in R3's and R4's medical records that R3's and R4's physicians and representatives were notified of the altercation on 7/12/22. On 8/2/22 at 9:43 AM R4 stated: A few weeks ago R3 grabbed my left arm, the one that I broke. R3 wasn't joking around. R4 had bumped R3's foot when R4 was trying to go around R3, and that upset R3. R3 used force to grab and pull my arm, it hurt my collarbone. On 8/2/22 at 10:31 AM V17 Housekeeper stated: R3 and R4's incident in July occurred near the nurse's station. V17 witnessed R4 attempt to walk past R3 in the smoking line, and R3 told R4 to wait. R3 grabbed R4's arm in an aggressive manor, and not in a playful nature. R3 and R4 were separated immediately. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/2/22 at 10:49 AM V1 Administrator stated: There should be an AIM (Assess Intervene Monitor for wellness) form/QA (Quality Assurance) form completed by the nurses in the residents record for abuse allegations that document physician and family notification, the incident, and resident assessment. A QA form/AIM form was not completed for R3's/R4's altercation. 2.) R1's Minimum Data Set (MDS) dated [DATE] documents R1 has severe cognitive impairment. R2's MDS dated [DATE] documents R2 has severe cognitive impairment. The facility's Final Report dated 7/22/22 documents the following: An exit door alarm sounded on the memory care unit and R1 was redirected back inside the facility. Upon returning to the facility R2 was talking to a staff member (V5 Licensed Practical Nurse (LPN)) and was brought to the nurse's station. R2 reported that R1 put R2's hands on R1. The facility's investigative file for R1's/R2's altercation contained interview statements that were conducted with V4 Registered Nurse (RN), V5 LPN and V12 LPN on 7/17/22 between 8:57 PM and 9:00 PM that document the following: V4 Registered Nurse was alerted to commotion on the memory care unit, and R1 and R2 were upset. R2 told V5 that R1 put R1's hands on R2. R2's Nursing Note dated 7/17/22 at an unidentified time documents: An altercation with another resident (R1) occurred, per resident statement to nurse. Residents neck is noticeably reddened, no other signs of injury. (R2) is upset and states not understanding why it (the incident) had occurred. Resident (R2) was brought out to TV (television) room in front of D hall to calm down and eat a snack. When brought back to B hall, (R2) showed signs of fear asked if the other resident (R1) was still here. There is no documentation in R2's medical record that V19 Physician or State Guardian were notified of the altercation with R1. There is no documentation in R1's medical record that V19 Physician was notified of the altercation with R2. R1's nursing note dated 7/17/22 at 8:50 PM documents attempts were made to contact V18 (R1's Family), but there was no answer and no way to leave a voicemail message. Will attempt to reach (V18) at a later time. There is no follow up documentation in R1's medical record that attempts were made again to contact V18, or that V18 was notified. The Quality Care Reporting Form dated 7/17/22 documents: R1's/R2's altercation was reported to V19 (R1's and R2's Physician) on 7/17/22 (but does not document a time), V18 was notified on 7/17/22 at 9:00 PM, and R2's State Guardian was notified on 7/17/22 at 9:00 PM. On 8/2/22 at 9:53 AM V4 Registered Nurse stated: V4 was working late on the evening of R1's/R2's incident. V4 was just getting ready to leave, and did not do any reporting of the incident. On 8/2/22 at 11:18 AM V5 Licensed Practical Nurse (LPN) stated: V5 attempted to notify R2's family, but there was no return call. V12 attempted to notify R1's family. I (V5) didn't notify the physician, I (V5) believe (V12 LPN) did that. On 8/2/22 at 11:59 AM V12 LPN stated: V12 had attempted to notify V18, but we did not have a current phone number. V12 never got in contact with V18. V12 did not notify R2's State Guardian or V19, and V4 was suppose to notify V19 Physician. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/2/22 at 9:05 AM V3 Assistance Director of Nursing stated V3 charted on R1's/R2's incident based on the information that was given to V3, because V12 did not complete the charting and has not returned to the facility. V3 confirmed V3 completed the Quality Care Reporting Forms dated 7/17/22, and that V3 did not notify R1's/R2's representatives and physician of the incident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40385 Based on interview and record review the facility failed to report an allegation of resident to resident verbal abuse timely to the Administrator and to the State Survey Agency for two (R5, R6) of six residents reviewed for resident to resident abuse in the sample list of 14. Findings include: The facility's Abuse Prevention Program with a revised date of 11/28/2016 documents: Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within hearing distance regardless of their age, ability to comprehend, or disability. Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator. The facility must ensure that all alleged violations involving mistreatment, exploitation, neglect or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency of jurisdiction and IDPH (Illinois Department of Public Health) immediately after forming the suspicion (but not later than two hours after forming the suspicion), Otherwise, the report must be made not later than 24 hours after forming the suspicion. On 8/2/22 at 12:59 PM V13 Unit Aide stated: One evening last week around 8:45 PM R5 told R6 this b**** (expletive) she stinks (referring to R6.) R6 then told R5 f*** (expletive) you (R5). The nurses (unidentified) and V14 Certified Nursing Assistant (CNA) were also present at the time the incident occurred. V13 did not report the incident to anyone. I (V13) would think it could be considered possible verbal abuse. The nurses told V13 that it was not considered abuse, so V13 did not report the incident. We are to report abuse allegations right away to V1 Administrator. On 8/2/22 at 2:22 PM R5 stated R6 is disgusting and loud on the phone. R5 stated R6 cusses at R5, calls R5 names, and says shut the f*** (expletive) up, you black n***** (expletive) to R5. R5 stated R5 told R6 that R6 is a nasty fat a** (expletive). R5 stated this happened about 3 days ago, and staff was nearby when it happened. On 8/2/22 at 2:51 PM V14 CNA stated: V14 has witnessed R6 curse at R5. It was within the last few weeks in the evening. Unidentified nurses were present at the time. R6 was on the phone in the dayroom and had the conversation on speakerphone. R5 was complaining about it, and R6 told R5 to shut the f*** (expletive) up. Abuse is to be reported immediately to V1. I would have reported the incident to V1, but the nurses were also there and should have reported it. V14 would consider residents cursing at each other to be possible verbal abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/22 at 1:44 PM V1 Administrator confirmed the incident between R5 and R6 was not reported to V1, and confirmed it should have been reported immediately as a verbal abuse allegation. On 8/3/22 at 4:50 PM V1 stated V1 did not report the verbal abuse allegation between R5/R6 that was reported on 8/2/22 to IDPH. V1 stated V1 did not report the incident to IDPH since the staff did not report the incident timely to V1.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 40385 Based on observation, interview and record review the facility failed to thoroughly investigate a resident to resident physical altercation for two of six residents (R1 and R2) reviewed for abuse in the sample list of 14. Findings include: The facility's Abuse Prevention Program with a revised date of 11/28/2016 documents: Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within hearing distance regardless of their age, ability to comprehend, or disability. The administrator or designee will be notified of all reports of potential/alleged mistreatment including abuse allegations, and the administrator/designee will initiate an investigation. Investigative procedures include conducting interviews with any witnesses and staff who had contact with the resident during the period of the alleged incident, and a review of all circumstances surrounding the incident. 1.) The facility's Final Report dated 7/22/22 documents the following: An exit door alarm sounded on the memory care unit and R1 was redirected back inside the facility. Upon returning to the facility R2 was talking to a staff member (V5 Licensed Practical Nurse (LPN)) and was brought to the nurse's station. R2 reported that R1 put R2's hands on R1. Facility Investigation was inconclusive as to whether altercation was indeed physical or only verbal due to no witnesses and no injuries assessed. The facility's investigative file for R1's/R2's altercation contained interview statements that were conducted with V4 Registered Nurse (RN) , V5 LPN and V12 LPN on 7/17/22 between 8:57 PM and 9:00 PM that document the following: V4 Registered Nurse was alerted to commotion on the memory care unit, and R1 and R2 were upset. R2 told V5 that R1 put R1's hands on R2. V12 responded to the sounding door alarm on the memory care unit and found R1 outside of the facility, saying R1 was a dumba** (expletive) for what she did. It was unclear as to what R1 was referring to. There is no documentation that staff witnessed the incident between R1 and R2. The Daily Assignment Sheet dated 7/17/22 documents two Certified Nursing Assistants (V14 and V16), one unit aide (V13) , and two nurses worked the second shift. V14 Certified Nursing Assistant (CNA) was assigned to B-Hall (memory care unit) after 6:00 PM. There is no documentation that V13, V14, or V16 were interviewed as part of the investigation. R2's Nursing Note dated 7/17/22 at an unidentified time documents: An altercation with another resident (R1) occurred, per resident statement to nurse. Residents neck is noticeably reddened, no other signs of injury. (R2) is upset and states not understanding why it (the incident) had occurred. Resident (R2) was brought out to TV (television) room in front of D hall to calm down and eat a snack. When brought back to B hall, (R2) showed signs of fear asked if the other resident (R1) was still here. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/2/22 at 11:18 AM V5 LPN stated: At the time of R1/R2 incident, V5 was just coming on shift and was getting report from V12 LPN. Unidentified staff had come to get V5 and V12 to report that while in the breakroom they heard a commotion from B-hall. V12 and V5 went to the unit and R2 reported that R1 had put R1's hands around R2's neck and choked her (R2). R2 had a worried, fearful expression when R2 reported this. V5 was not sure if any staff were present on B-hall when the incident occurred. I (V5) believe (R2) told (R1) to get out of her (R2's) house since R2 believes this (the facility) is her (R2's) house, and then (R1) grabbed (R2's) neck. On 8/2/22 at 11:59 AM V12 LPN stated: No staff was present on B-Hall at the time of R1's/R2's incident. The incident happened between 8:00 PM and 8:20 PM. V4, V5, and V12 were on the main part of the facility when V12 heard a door alarm sound from B-Hall. R1 was attempting to elope from the facility. R1 was brought back inside and R2 told V5 that R1 had grabbed R2 around the neck. R2's neck was visibly red on both sides, and you could tell that someone had grabbed R2's neck. R2 seemed scared and threatened. R1 said yes when staff asked R1 if R1 had grabbed R2 around the neck. On 8/2/22 at 8:03 AM R1 and R2 were on B-Hall. There was a video surveillance camera positioned at the double door entrance that faced the patio exit door located at the end of the hallway. On 8/2/22 at 11:16 AM V1 Administrator stated R1's/R2's altercation happened somewhere on B-Hall. V1 confirmed that no staff witnessed the altercation. V1 stated the following: Camera footage was not reviewed as part of the investigation for the alleged incident between R1 and R2. Sometimes we review video surveillance, but it only holds recorded data for 48 hours. By the time V1 had obtained staff interview statements, the video surveillance footage was no longer there to review for the time frame of the alleged incident. V1 confirmed V13, V14, and V16 were not interviewed as part of the investigation for the incident between R1 and R2.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview, observation, and record review the facility failed to give showers as scheduled for three (R7, R5, R4) of three residents reviewed for bathing assistance in the sample list of 14. Findings include: 1.) R7's Minimum Data Set (MDS) dated [DATE] documents R7 requires physical assistance of one staff person for bathing. The facility's undated shower schedule documents R7's showers are scheduled twice weekly on Monday and Thursday. R7's Shower Sheets from 7/22/22-8/3/22 were requested and provided by V2 Director of Nursing. There is no documentation that a shower was offered or given to R7 after 7/25/22. On 8/3/22 at 9:11 AM R7 stated R7 has not had a shower since last week, and R7 is scheduled to receive showers twice per week. 2.) R5's MDS dated [DATE] documents R5 is cognitively intact and requires supervision of one staff for bathing assistance. The facility's undated shower schedule documents R5's showers are scheduled twice weekly on Tuesday and Friday. R5's Shower Sheets from 7/22/22-8/3/22 were requested and provided by V2. There is no documentation that a shower was offered or given to R5 after 7/22/22. On 8/4/22 at 12:18 PM R5 hair appeared long, dark, and greasy. R5 stated R5 readmitted to the facility on [DATE], and has only had 1 shower since then. R5 stated R5 would like to have a shower at least twice per week. 3.) R4's MDS dated [DATE] documents R4 requires physical assistance of one staff person for bathing. The facility's undated shower schedule documents R4's showers are scheduled twice weekly on Tuesday and Friday. R4's Shower Sheets from 7/22/22-8/3/22 were requested and provided by V2. There is no documentation that a shower was offered or given to R4 after 7/25/22. On 8/3/22 at 9:56 AM R4 stated R4 gets a shower once per week, and hasn't had one since last week. R4's hair appeared long, dark, and greasy. On 8/3/22 at 2:33 PM V2 confirmed all of the requested shower documentation for R7, R5, and R4 was provided. V2 stated showers are scheduled twice weekly.

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	145389	A. Building B. Wing	08/04/2022

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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** 40385 Based on observation, interview and record review the facility failed to monitor weights, monitor pulse oximetry levels, complete skin assessments, label a wound dressing with a date, and follow physician orders for seven (R7, R12, R6, R13, R5, R14, R9) of nine residents reviewed for quality of care in the sample list of 14. These failures resulted in R7 being unnecessarily put at risk for developing exacerbation of Congestive Heart Failure. Findings include: 1.) On 8/3/22 at 9:11 AM R7 was sitting in a recliner in R7's room wearing oxygen per nasal cannula at 4 liters/minute. R7's bilateral lower extremities were in a dependent position and were edematous/swollen. R7 lifted R7's abdominal folds, and the skin was red/intact at this time. R7 stated: R7 was unable to wear R7's slippers due to R7's edema. The facility was suppose to order another inhaler, Trelegy, over a week ago, but it never came in. R7 gets short of breath at times and making it difficult to do therapy. R7 is borderline diabetic, and the facility has only checked R7's blood glucose level twice. R7 has not been weighed since R7 admitted to the facility on [DATE]. R7 had admitted to the facility with open area to R7's coccyx and abdominal folds. R7's August 2022 Physician's Orders documents R7 has a diagnosis of Congestive Heart Failure, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. R7's Hospital Discharge Summary dated 7/13/22 documents orders to weigh R7 daily, check blood glucose four times daily before meals and at bedtime, administer Budesonide 0.25 mg (milligram)/2 ml (milliliter) nebulizer twice daily, and Ipratropium-Albuterol 0. 5-2.5 mg/3 ml nebulizer four times daily as needed for shortness of breath. R7's Admission Physician's Orders dated 7/13/22 documents orders for Furosemide (diuretic) 40 mg by mouth twice daily. R7's August 2022 Physician's Orders document to complete a daily skin check. There is no documentation that the hospital discharge orders for daily weights, blood glucose checks, Budesonide, and Ipratropium-Albuterol were transcribed to R7's July and August 2022 physician order sheets. R7's Physician Order dated 8/1/22 documents an order for Trelegy Ellipta 100-62.5-25 microgram inhaler take 1 puff daily. R7's August 2022 Medication Administration Record does not document that Trelegy was administered prior to 8/3/22. There is no documentation in R7's medical record that this medication was ordered prior to 8/1/22. There is no documentation in R7's medical record that daily weights or blood glucose were obtained as ordered, or that Budesonide and Ipratropium-Albuterol were administered. R7's July 2022 Medication Administration Record (MAR) does not document Furosemide on 7/13, 7/14, and the morning of 7/15/22. R7's July 2022 Treatment Administration Record (TAR) documents R7's skin was checked daily, but does not record if R7's skin was intact or open. R7's shower sheet dated 7/25/22 does not document if R7's skin is intact or if R7 has an open/red/excoriated areas. R7's Nursing Notes document R7's dependent edema is first recorded on 7/18/22. There is no documentation that R7 had edema prior to 7/18/22. There is no documentation in R7's medical record that R7's pulse oximetry levels were routinely monitored. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/3/22 at 2:12 PM V3 Assistant Director of Nursing stated skin assessments are completed weekly by the nurses. On 8/3/22 at 3:20 PM V3 stated the skin assessments are documented on the TAR or shower sheet. V3 confirmed the skin assessments should document whether the skin is intact, open, and if there were any new problem areas. On 8/3/22 at 4:32 PM V3 stated pulse oximetry should be obtained twice daily. On 8/3/22 at 2:39 PM V2 Director of Nursing stated: Trelegy was ordered on 8/1/22 after V11 (R7's Family) told V2 that the Trelegy was ordered about a week ago and that R7 had not received the medication. V2 could was unable to locate an order for Trelegy prior to 8/1/22. Trelegy was delivered to the facility on [DATE], and V2 was not sure why the nurses did not administer it prior to 8/3/22. V2 admitted with orders for nebulizers, but the nurses said they didn't administer the nebulizers due to COVID-19 (human coronavirus infection). The nurses should have administered R7's nebulizer treatments or contacted the physician to get alternate orders. R7's hospital discharge orders included to check blood sugar three times daily and at bedtime. V2 received and implemented orders to check R7's blood sugars as of today. order for blood glucose levels were not implemented as ordered. On 8/3/22 at 4:02 PM V2 DON confirmed there is no documentation that R7 had edema prior to 7/18/22. V2 stated the nurses should have followed up with the physician and documented in the medical record. On 8/3/22 at 4:30 PM V2 confirmed R7's medical record did not document pulse oximetry readings. On 8/4/22 at 8:30 AM V2 stated there were no documented weights in R7's medical record for July/August 2022. On 8/4/22 at 11:40 AM V15 Physician stated: V15 was not aware that R7 had missed doses of medications or that R7 had edema to bilateral lower extremities. R7 has Congestive Heart Failure (CHF). The facility should have continued to monitor R7's weight daily as ordered. R7 has been in and out of the hospital multiple times in the last few months. V15 was told the facility had COVID-19 (Human Coronavirus Infection) and could not administer nebulizers, so V11 (R7's Family) requested Trilegy inhaler for R7 instead of the nebulizers. V15 gave the order for Trelegy to the facility over a week ago, and V11 complained to V15 that it took awhile before R7 received the medication. The facility should have administered R7's medications as ordered. Not monitoring weights for a patient with a diagnosis of CHF could cause the person to go into an acute exacerbation of CHF and cause a decline in condition. 2.) On 8/3/22 at 2:12 PM V21 Certified Nursing Assistant (CNA) and V3 Assistant Director of Nursing (ADON) cleansed R12's abdominal folds. There was a linear, pink, open wound to R12's left abdominal fold. V3 applied a barrier cream to the wound. V3 stated R12's wound was identified on 8/2/22 during R12's bedbath, and is related to moisture/heat or friction. V3 stated the nurses are responsible for completing skin assessments weekly, and R12 should has daily skin assessments. On 8/3/22 at 3:20 PM V3 Assistant Director of Nursing stated skin assessments should be documented on the TAR or a shower sheet. V3 confirmed the skin assessments should document if the skin is intact, open, and any new problem areas. V3 stated V3 has R12's wound measurements and assessment from 8/2/22 written on a note, and has not documented the information in R12's medical record yet. R12's July 2022 and August 2022 TARs do not document skin assessments were completed daily or weekly. R12's shower sheets dated 7/23/22 and 7/28/22 do not document the status of R12's skin integrity. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Facility's Weekly Wound Tracking dated 8/3/22 documents R12's abdominal wound measured 0.4 cm (centimeters) long by 3.5 cm wide by 0.1 cm deep. There is no documented assessment/description of R12's abdominal wound in R12's medical record, prior to 8/3/22. 3.) R6's August 2022 TAR documents: Cleanse R6's left and right leg wounds with normal saline, dry, apply medihoney and cover with a dry dressing daily. Daily cleanse R6's right foot wound with normal saline, dry, apply medihoney and alginate, cover with an abdominal pad, wrap up to knee with gauze, and apply a stretch stockinet over the gauze. Daily cleanse R6's left foot wound with normal saline, dry, apply medihoney, cover with abdominal pad, wrap up to knee with gauze, and apply a stretch stockinet over the gauze. On 8/3/22 at 1:21 PM V3 ADON entered R6's room to administer R6's wound treatments. V3 removed R6's undated wound dressings from R6's bilateral lower extremities (BLE). R6 had open wounds to the right shin, left inner posterior knee, top of left foot, top of right foot. V3 stated the wounds are vascular and R6 picks at R6's skin/wounds. V3 confirmed R6's BLE wound dressings were not labeled with a date. On 8/3/22 at 2:18 PM V3 stated wound dressings should be labeled with a date. 4.) On 8/4/22 at 7:55 AM R13 stated sometimes the facility doesn't obtain R13's weight, and R13 should be weighed at least twice weekly. R13 stated R13 goes to dialysis three times weekly. R13's Physician's Orders dated 7/25/22 document R13 has a diagnosis of End Stage Renal Disease and that R13 receives dialysis. There are no orders to obtain R13's weight routinely. There are no documented weights for July/August 2022 in R13's medical record. On 8/3/22 at 3:20 PM V2 DON stated residents who receive dialysis should have weights obtained weekly. On 8/4/22 at 8:30 AM V2 DON stated weight monitoring is an area that needs improvement. V2 provided a monthly weight report that documents R13's weight was 157.4 pounds in July 2022. This report does not document the date this weight was obtained, or document R13's August weight. V2 confirmed there were no other recorded weights for R13 in July/August 2022. V2 stated R13's August weight is 168.4 pounds. V2 stated V2 was unable to locate documentation for how often R13 should be weighed. 5.) On 8/4/22 at 12:18 PM R5 stated: R5 has not been weighed in the facility, other than on admission in April 2022 and this past Monday (8/1/22). R5 thought the facility is suppose to weigh R5 weekly. R5 receives dialysis three times per week. There are no orders in R5's medical record to obtain R5's weight regularly. There are no documented weights recorded for July/August 2022. On 8/4/22 at 8:30 AM V2 confirmed there were no documented weights for July/August 2022 in R5's medical record. V2 provided a copy of the facility's monthly weight report that does not list R5 or documented weights for R5 for April-August 2022. V2 stated on 7/5/22 R5 weighed 110 pounds, and on 8/3/22 R5 weighed 129 pounds. V2 stated V2 was unable to locate documentation/orders for how frequent R5 should be weighed. 6.) R14's August 2022 Physician's Orders document to obtain blood glucose checks before meals at 8:00 AM, 11:00 AM, 4:00 PM, and record the results. R14's July 2022 MAR does not document the results of R14's blood glucose check for a total of 59 entries. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/3/22 at 10:05 AM V10 Licensed Practical Nurse (LPN) obtained R14's blood glucose level of 282. 7.) R9's July 2022 MAR documents R9's blood glucose checks are scheduled at 7:30 AM, 11:30 AM, 4:30 PM, and 8:30 PM, and documents to record the results. This MAR documents an entry to administer Novolog insulin per sliding scale four times daily based on R9's blood glucose results. There are a total of 56 entries that do not document the results of R9's blood glucose level. R9's August 2022 MAR documents R9's blood glucose checks are scheduled at 7:30 AM, 11:00 AM, 4:00 PM, and 8:00 PM, and to administer Novolog insulin per sliding scale four times daily based on R9's blood glucose results. This MAR does not document R9's blood glucose result on 8/3/22 at 7:30 AM, 8/1/22 at 11:00 AM and 4:00 PM, or on 8/1 and 8/2/22 at 8:00 PM. On 8/3/22 at 10:50 AM V10 LPN obtained R9's blood glucose level of 294. V10 stated this is R9's noon blood glucose check, since V10 did not complete R9's morning blood glucose check timely. On 8/4/22 at 2:08 PM V2 DON stated the nurses should be recording blood glucose results on the MAR. V2 confirmed R14's and R9's MARs were missing documentation of blood glucose results. The facility's Medication Administration policy dated as revised 11/18/17 documents to notify the physician if a scheduled dose of medication was not administered or available. The facility's Nursing Documentation Guidelines policy revised January 2005 documents vital signs are to be completed every shift for 3 days for newly admitted and readmitted residents, and to document vital signs in the medical record. Weekly skin observations should be completed and documented for residents at moderate and high risk for skin impairment. Weights should be recorded with the date and time the weight was obtained. The facility's Resident Weight Monitoring policy dated March 2019 documents: weights will be monitored at least monthly, significant weight changes are reviewed weekly, and new admissions/re-admissions weights will be obtained weekly for 4 weeks.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to provide adequate supervision of a memory care unit resulting in an unwitnessed resident to resident altercation for two (R1, R2) of six residents reviewed for resident to resident abuse in the sample list of 14. Findings include: The Daily Assignment Sheet dated 7/17/22 documents two Certified Nursing Assistants (V14 and V16), one unit aide (V13) , and two nurses worked the second shift. V14 Certified Nursing Assistant (CNA) was assigned to B-Hall (memory care unit) after 6:00 PM. R1's Minimum Data Set (MDS) dated [DATE] documents R1 has severe cognitive impairment, and had physical behaviors directed towards others 1-3 days during the 7 day review period. R1 requires supervision and setup assistance for transfers and walking. R2's MDS dated [DATE] documents R2 has severe cognitive impairment, and had verbal behaviors directed towards others 1-3 days during the 7 day review period. R2 requires supervision and setup assistance from staff with walking. R2's Social Service Notes document on 7/7/22 R2 was verbally aggressive with staff and other residents, and on 7/15/22 R2 was angry and telling staff to get out of R2's house. The facility's Final Report dated 7/22/22 documents the following: An exit door alarm sounded on the memory care unit and R1 was redirected back inside the facility. Upon returning to the facility R2 was talking to a staff member (V5 Licensed Practical Nurse (LPN)) and was brought to the nurse's station. R2 reported that R1 put R2's hands on R1. Facility Investigation was inconclusive as to whether altercation was indeed physical or only verbal due to no witnesses and no injuries assessed. The facility's investigative file for R1's/R2's altercation contained interview statements that were conducted with V4 Registered Nurse (RN) , V5 LPN and V12 LPN on 7/17/22 between 8:57 PM and 9:00 PM that document the following: V4 Registered Nurse was alerted to commotion on the memory care unit, and R1 and R2 were upset. R2 told V5 that R1 put R1's hands on R2. V12 responded to the sounding door alarm on the memory care unit and found R1 outside of the facility, saying R1 was a dumba** (expletive) for what she did. It was unclear as to what R1 was referring to. There is no documentation that staff witnessed the incident between R1 and R2. R2's Nursing Note dated 7/17/22 at an unidentified time documents: An altercation with another resident (R1) occurred, per resident statement to nurse. Residents neck is noticeably reddened, no other signs of injury. (R2) is upset and states not understanding why it (the incident) had occurred. Resident (R2) was brought out to tv (television) room in front of D hall to calm down and eat a snack. When brought back to B hall, (R2) showed signs of fear asked if the other resident (R1) was still here. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/22 at 9:53 AM V4 RN stated: V4 worked late on 7/17/22, and heard a commotion on B-Hall. V4 told V12 LPN to go to B-Hall. When V4 got to B-Hall, V12 had already separated R1 and R2. R1 and R2 were upset and yelling at each other, and R2 was crying. On 8/2/22 at 11:18 AM V5 LPN stated: At the time of R1/R2 incident, V5 was just coming on shift and was getting report from V12 LPN. Unidentified staff had come to get V5 and V12 to report that while in the breakroom they heard a commotion from B-hall. V12 and V5 went to the unit and R2 reported that R1 had put R1's hands around R2's neck and choked her (R2). R2 had a worried, fearful expression when R2 reported this. V5 was not sure if any staff were present on B-hall when the incident occurred. I (V5) believe (R2) told (R1) to get out of her (R2's) house since R2 believes this (the facility) is her (R2's) house, and then (R1) grabbed (R2's) neck. On 8/2/22 at 11:59 AM V12 LPN stated: No staff was present on B-Hall at the time of R1's/R2's incident. The incident happened between 8:00 PM and 8:20 PM. That night we only had 2 CNAs and 1 unit aide working. V4, V5, and V12 were on the main part of the facility when V12 heard a door alarm sound from B-Hall. R1 was attempting to elope from the facility. R1 was brought back inside and R2 told V5 that R1 had grabbed R2 around the neck. R2's neck was visibly red on both sides, and you could tell that someone had grabbed R2's neck. R2 seemed scared and threatened. R1 said yes when staff asked R1 if R1 had grabbed R2 around the neck. We are supposed to have someone assigned to to work B-Hall, but there have been several times where we didn't have enough staff due to call offs. On 8/2/22 at 12:59 PM V13 Unit Aide confirmed V13 was not on B-hall at the time R1's/R2's incident occurred on 7/17/22. On 8/2/22 at 2:35 PM V16 CNA confirmed V16 was not on B-hall at the time of R1's/R2's incident. On 8/2/22 at 2:51 PM V14 CNA stated: V14 was working on D-Hall at the time of R1's/R2's incident. A lot of time we are short staffed and don't have anyone working on the memory care unit. R2 gets upset at times and tells other residents to get out of R2's house. On 8/2/22 at 4:42 PM V3 Assistant Director of Nursing confirmed the Daily Assignment Sheet for 7/17/22 documents the correct number of staff that worked and assigned halls. On 8/2/22 at 11:16 AM V1 Administrator stated R1's/R2's altercation happened somewhere on B-Hall. V1 confirmed that no staff witnessed the altercation. V1 stated there should always be a staff person on B-Hall to supervise the unit.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40385 Based on observation, interview, and record review the facility failed to sufficiently staff nurses and Certified Nursing Assistants. This failure has the potential to affect all 74 residents residing in the facility Findings include: 1.) The Daily Assignment Sheet dated 7/17/22 documents two Certified Nursing Assistants (V14 and V16), one unit aide (V13) , and two nurses worked the second shift. V14 Certified Nursing Assistant (CNA) was assigned to B-Hall (memory care unit) after 6:00 PM, and V16 was assigned to A and C Halls. The facility's Final Report dated 7/22/22 documents the following: An exit door alarm sounded on the memory care unit and R1 was redirected back inside the facility. Upon returning to the facility R2 was talking to a staff member (V5 Licensed Practical Nurse (LPN)) and was brought to the nurse's station. R2 reported that R1 put R2's hands on R1. R2's Nursing Note dated 7/17/22 at an unidentified time documents: An altercation with another resident (R1) occurred, per resident statement to nurse. Residents neck is noticeably reddened, no other signs of injury. (R2) is upset and states not understanding why it (the incident) had occurred. Resident (R2) was brought out to tv (television) room in front of D hall to calm down and eat a snack. When brought back to B hall, (R2) showed signs of fear asked if the other resident (R1) was still here. On 8/2/22 at 11:18 AM V5 LPN stated: At the time of R1/R2 incident, V5 was just coming on shift and was getting report from V12 LPN. Unidentified staff had come to get V5 and V12 to report that while in the breakroom they heard a commotion from B-hall. V12 and V5 went to the unit and R2 reported that R1 had put R1's hands around R2's neck and choked her (R2). R2 had a worried, fearful expression when R2 reported this. V5 was not sure if any staff were present on B-hall when the incident occurred. On 8/2/22 at 11:59 AM V12 LPN stated: No staff was present on B-Hall at the time of R1's/R2's incident. The incident happened between 8:00 PM and 8:20 PM. That night we only had 2 CNAs and 1 unit aide working. V4, V5, and V12 were on the main part of the facility when V12 heard a door alarm sound from B-Hall. R1 was attempting to elope from the facility. R1 was brought back inside and R2 told V5 that R1 had grabbed R2 around the neck. R2's neck was visibly red on both sides, and you could tell that someone had grabbed R2's neck. R2 seemed scared and threatened. R1 said yes when staff asked R1 if R1 had grabbed R2 around the neck. We are supposed to have someone assigned to to work B-Hall, but there have been several times where we didn't have enough staff due to call offs. On 8/2/22 at 2:35 PM V16 CNA confirmed V16 was not on B-hall at the time of R1's/R2's incident. On 8/2/22 at 2:51 PM V14 CNA stated: V14 was working on D-Hall at the time of R1's/R2's incident. A lot of time we are short staffed and don't have anyone working on the memory care unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/2/22 at 4:42 PM V3 Assistant Director of Nursing (ADON) confirmed the Daily Assignment Sheet for 7/17/22 documents the correct number of staff that worked and hall assignments. On 8/3/22 at 8:30 AM V3 stated the following: The facility's minimum CNA staffing is four on dayshift, 3 on evening shift and two on night shift. B-Hall should have an assigned CNA, and they have been instructed that someone has to stay on the unit. The facility's current census is 74 residents. 2.) On 8/3/22 at 8:00 AM V9 Registered Nurse (RN) and V10 LPN were passing medications on the A and C halls. V9 and V10 were the only nurses observed working the floor in the facility. On 8/3/22 at 10:13 AM V10 prepared R8's morning medications. V10 entered R8's room to administer the medications. R8 was lying in bed and refused to take the medications. V10 stated V10 is new to the facility, and V10 would have started morning medication pass on B-Hall (R8's unit) if V10 was informed that R8 won't take R8's medications once R8 is in bed. R10's August 2022 Medication Administration Record (MAR) documents R8's morning medications are scheduled to be given at 9:00 AM. On 8/3/22 at 10:34 AM V10 prepared and administered R9's morning medications. On 8/3/22 at 10:50 AM V10 obtained R9's blood glucose level of 294. V10 stated this will be R9's noon blood glucose check, since V10 did not get to R9's blood glucose check this morning. R9's August 2022 MAR documents the following: R9's blood glucose checks are scheduled to be done before meals and at bedtime (8:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM) with corresponding sliding scale Novolog insulin administrations based on the blood glucose results. R9's morning medications are scheduled to be given at 8:00 AM. On 8/3/22 at 11:08 AM V9 RN was passing medications. V9 stated V9 has not finished V9's morning medication pass yet, and R10 is the last resident that V9 has to administer morning medications to. V9 stated it is a lot of medications to pass in the morning and with interruptions we get behind. V9 stated we (V9 and V10) are both new to the facility and are both agency nurses. On 8/3/22 at 11:11 AM V9 prepared and administered R10's morning medications. On 8/3/22 at 11:56 AM V9 stated we have an hour window before and after the scheduled time to give medications. R10's August 2022 MAR documents morning medications are scheduled to be given at 8:00 AM. On 8/3/22 at 8:30 AM V3 ADON stated as of August 1st we schedule 3 nurses to work on days and 3 on evenings, and prior to that it was two nurses on days and two nurses on evenings. V3 stated V3 has worked as the only nurse in the facility at times. V3 confirmed V3 worked as the only nurse on dayshift on 7/23/22, 7/24/22, and 7/29/22; and V4 RN worked as the only nurse on dayshift on 7/30/22. V3 stated the facility's census is 74 residents. On 8/3/22 at 1:15 PM V3 stated there were 3 nurses scheduled to work dayshift today, but V4 RN did not show up to work. V3 stated the facility's current census is 74 residents. The Daily Assignment Sheets document the following: V3 Assistant Director of Nursing is the only nurse assigned to work on dayshift on 7/23, 7/24, and 7/29/22. V4 RN is the only nurse assigned to work on dayshift on 7/30/22. The Resident Roster provided by V1 Administrator on 8/2/22, dated 7/31/22, documents 74 residents reside in the facility.

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Watseka Rehab & Hlth Care Ctr	715 East Raymond Road Watseka, IL 60970

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to provide behavioral interventions for a resident (R3) with a history of physical altercations. This failure affects two (R3, R4) of six residents reviewed for resident to resident abuse in the sample list of 14. Findings include: The facility's Final Report dated 7/15/22 documents there was an allegation of a physical altercation between R3 and R4, and the facility concluded that the allegation occurred most likely due to resident diagnosis. V17 Housekeeper written interview dated 7/12/22 at 9:30 AM documents R3 put R3's foot out and try to block R4 from going past R3, R4 attempted to go around R3, and R3 grabbed R4's arm. R4's interview statement dated 7/12/22 documented at 10:00 AM documents R4 was trying to get in line to go smoke, R3 told R4 to get out of R3's way, R3 grabbed R4's arm and pulled R4's arm and pulled R4 back. The facility's 2021/2022 Abuse Allegation Log documents R3 was involved in four resident to resident altercations since December 2021. R3's August 2022 Physician's Orders documents R3 has diagnoses of Schizoaffective Disorder and Bipolar. R3's order dated 4/7/22 documents to administer Latuda (antipsychotic) 100 mg (milligrams) by mouth daily in the morning for Schizoaffective Disorder. R3's order dated 10/21/20 documents to administer Zoloft (antidepressant) 25 mg by mouth in the morning 6 times per week for Depression. R3's order dated 6/11/21 documents to administer Trazodone (antidepressant) 150 mg by mouth daily. R3's Minimum Data Set, dated dated dated [DATE] documents R3 has moderate cognitive impairment and requires supervision with setup assistance for locomotion on and off the unit. R3's Care Plan dated as reviewed on 7/8/22. does not address R3's behaviors directed towards others or interventions to address R3's behaviors. R3's June 2022 Behavior Tracking documents R3 has a targeted behavior of outbursts towards staff and others and does not document whether R3 has had any behaviors in June. There are no behavior tracking forms for July and August 2022 in R3's medical record. There is no documentation that any behavioral interventions were developed/implemented or that behavioral services were provided after R3's altercation with R4 on 7/12/22. On 8/2/22 at 10:31 AM V17 Housekeeper stated: R3 and R4's incident in July occurred near the nurse's station. R4 attempted to pass R3, and R3 told R4 to wait. R3 grabbed R4's arm in an aggressive manor, and not in a playful nature. R3 and R4 were separated immediately. On 8/2/22 at 2:11 PM V3 Assistant Director of Nursing stated R3 has a history of resident to resident altercations and R3's care plan was updated with each incident. V3 confirmed R3's current care plan does not document R3's behaviors or altercations and interventions. On 8/2/22 at 4:42 PM V3 stated R3's behavior tracking sheets were not implemented for July and August 2022. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/22 at 4:50 PM V1 Administrator stated: V1 stated there were no behavioral interventions that were implemented for R3 after the incident with R4 that occurred in July. V1 stated we have not had psychiatric services offered in the facility since May 2022, and we do not utilize outside psychiatric services or therapy services. V1 stated R3's resident to resident altercations are related to R3's diagnoses of Schizoaffective Disorder and Bipolar. On 8/4/22 at 8:40 AM V2 Director of Nursing stated R3 has not had any adjustments in R3's psychotropic medications after the altercation with R4 in July 2022.

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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. 40385 Based on observation, interview, and record review the facility failed to administer medications timely and in accordance with physician orders for four (R8, R9, R10, R11) of four residents reviewed for medication administration in the sample list of 14. This failure resulted in 28 medication errors out of 28 opportunities, a 100 % medication error rate. Findings include: 1.) R8's August 2022 Physician's Orders documents the following: Aspirin 81 mg (milligrams) give one tablet by mouth daily at 9:00 AM. Atenolol 25 mg give one tablet by mouth daily at 9:00 AM. Atorvastatin 20 mg daily at bedtime. Vitamin D3 25 mcg (micrograms) daily at 9:00 AM. Calcium 600 mg one tablet daily at 9:00 AM. Multivitamin one tablet daily at 9:00 AM. R8's August 2022 Medication Administration Record (MAR) documents R8's Atorvastatin 20 mg is scheduled to be given twice daily at 9:00 AM and 9:00 PM, not once daily as ordered. On 8/3/22 at 10:13 AM V10 Licensed Practical Nurse (LPN) prepared R8's morning medications including Aspirin 81 mg, Atenolol 25 mg, Atorvastatin 20 mg, Calcium 600 mg, and multivitamin. V10 entered R8's room to administer R8's the medications listed. R8 was lying in bed and refused to take R8's medications. V10 stated V10 did not have Vitamin D3 to administer, and V10 will follow up with R8's family to see if the medication is going to be delivered. On 8/3/22 at 2:20 PM V10 stated V10 has not followed up on R8's Vitamin D3. On 8/3/22 at 4:32 PM V2 Director of Nursing confirmed R8's Atorvastatin is ordered to be given once daily, and not twice daily as the MAR documents. 2.) R9's June 2022 document the following: Atorvastatin 10 mg daily at 8:00 AM, Fenofibrate 160 mg daily at 8:00 AM, Lisinopril 20 mg daily at 8:00 AM, Loratadine 10 mg daily at 8:00 AM, multivitamin with minerals one tablet daily at 8:00 AM, Oxybutynin 10 mg daily at 8:00 AM, Vitamin D3 50 mcg daily at 8:00 AM, Fish Oil 1000 mg twice daily at 8:00 AM and 8:00 PM, Flonase 0.05 % 1 spray each nostril twice daily at 8:00 AM and 8:00 PM, Namenda 5 mg twice daily at 8:00 AM and 8:00 PM, Metoprolol 12.5 mg at 8:00 AM and 8:00 PM, Acetaminophen 500 mg two tablets at 8:00 AM, 11:00 AM, and 4:00 PM, Refresh eye drops 1 drop both eyes at 8:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM, and Novolog insulin per sliding scale based on blood sugar results at 7:30 AM, 11:30 AM, 4:30 PM, and 8:30 PM. On 8/3/22 at 10:34 AM V10 prepared and administered R9's morning medications. V10 did not administer Lisinopril or Flonase. V10 returned to R9's room at 10:50 AM to obtain R9's blood sugar of 294. V10 stated this will be R9's noon blood sugar and insulin, since V10 did not complete the morning blood sugar check. V10 did not administer Novolog 8 units as ordered per the sliding scale. On 8/3/22 at 11:05 AM V10 stated all of R9's morning medications were administered, except Lisinopril and Novolog. V10 stated V10 did not see Flonase was scheduled. On 8/3/22 at 2:20 PM V10 stated R9's noon dose of Novolog has not been administered since the medication has not arrived yet from the pharmacy. V10 stated V10 has not done any follow up regarding R9's Lisinopril that was not available or administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) R10's August 2022 Physician's Orders document the following: Multivitamin one tablet daily at 8:00 AM, Losartan Potassium 50 mg daily at 8:00 AM, Calcium 600 mg with Vitamin D3 400 mg twice daily at 8:00 AM and 5:00 PM, Furosemide 20 mg twice daily at 8:00 AM and 4:00 PM 3 times per week, Metformin 500 mg twice daily at 8:00 AM and 4:00 PM, and Potassium Chloride 20 meq (milliequivalents) twice daily at 8:00 AM and 8:00 PM. R10's August 2022 MAR documents Augmentin 875 mg is scheduled to be given at 8:00 AM and 8:00 PM. On 8/3/22 at 11:08 AM V9 RN was passing medications. V9 stated V9 has not finished V9's morning medication pass yet, and R10 is the last resident that V9 has to administer morning medications to. On 8/3/22 at 11:29 AM V9 prepared administered R10's Multivitamin, Metformin, Calcium with Vitamin D, Furosemide, and Potassium. V9 did not administer Losartan Potassium or Augmentin. On 8/23/22 at 11:56 AM V9 administered R10's Augmentin. V9 stated V9 was unable to locate Losartan Potassium, and it would need to be ordered. On 8/3/22 at 11:56 AM V9 stated we have an hour window before and after the scheduled time to give medications. R10's August 2022 MAR documents morning medications are scheduled to be given at 8:00 AM. On 8/3/22 at 2:25 PM R10's Losartan Potassium was delivered to the facility. 4.) R11's August 2022 Physician's Orders document Breo Ellipta 200-25 mcg inhale 1 puff by mouth daily at 8:00 AM. On 8/4/22 at 11:44 AM V4 RN administered Breo Ellipta 100-25 mcg (micrograms) one puff to R11, and not 200-25 mcg as ordered. On 8/4/22 at 11:48 AM V4 confirmed R11's Breo Ellipta inhaler is not the dosage that is ordered. On 8/4/22 at 10:35 AM V2 Director of Nursing stated V2 expects physician's orders to be followed. The facility's Medication Administration Policy with a revised date of 11/18/17 documents: Medications must be prepared and administered within one hour of the designated time or as ordered. If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available. The facility's Adverse Drug Reactions and Medication Discrepancy policy dated as reviewed on 11/6/18 documents: A medication discrepancy/error has been made when one of the following occurs: Wrong medication administered. Wrong dose administered. Medication administered by wrong route. Medication administered to wrong resident. Medication administered at wrong time. Medication not administered.

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F 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 40385 Based on interview and record review the facility failed to administer medications as ordered, missing multiple doses of anticoagulants and cardiac medications, for one (R7) of seven residents reviewed for medications in the sample list of 14. Findings include: R7's August 2022 Physician's Orders document R7's diagnosis include gastrointestinal bleed, history of Atrial Fibrillation, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Hypertension. R7's Admission Physician's Orders dated 7/13/22 documents orders for Eliquis (anticoagulant) 5 mg by mouth twice daily, Diltiazem Hydrochloride (antihypertensive) 180 mg by mouth daily, Furosemide (diuretic) 40 mg by mouth twice daily, and Lisinopril (antihypertensive) 30 mg by mouth daily. R7's July 2022 Medication Administration Record (MAR) does not document the following medications were administered as ordered: Furosemide on 7/13, 7/14, and the morning of 7/15/22. Eliquis at 8:00 AM on 7/14 and 7/15/22. Diltiazem and Lisinopril on 7/14 and 7/15/22. There is no documentation in R7's medical record that R7's vital signs and weights are routinely monitored. R7's Nursing Notes documet R7 had dependent edema first recorded on 7/18/22. On 8/3/22 at 9:11 AM R7 was sitting in a recliner in R7's room. R7's feet were edematous and R7 was wearing oxygen at 4 liters/minute per nasal cannula. On 8/4/22 at 8:40 AM V2 Director of Nursing reviewed R7's July 2022 MAR and confirmed there is no documentation that Eliquis, Diltiazem, Furosemide, and Lisinopril were administered as ordered on the dates listed. On 8/4/22 at 10:35 AM V2 stated V2 expects physician's orders to be followed. On 8/4/22 at 11:50 AM V15 Physician stated the following: R7 has been in and out of the hospital in the past few months. Eliquis is very important because of R7's history of Atrial Fibrillation, and missing doses could cause serious consequences such as a stroke. Missing doses of Diltiazem could increase blood pressure and also cause a stroke. Missing doses of Lasix (Furosemide) could exacerbate R7's Congestive Heart Failure and cause edema. The facility's Medication Administration policy dated as revised on 11/18/17 documents when administering medications, record the date, time, medication, and dosage on the resident's MAR. The facility's Adverse Drug Reactions and Medication Discrepancy policy dated as reviewed on 11/6/18 documents: A medication discrepancy/error has been made when one of the following occurs: Wrong medication administered. Wrong dose administered. Medication administered by wrong route. Medication administered to wrong resident. Medication administered at wrong time. Medication not administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40385 Based on observation, interview, and record review the facility failed to ensure medications were labeled appropriately for three (R8, R9, R11) of four residents reviewed for medication administration in the sample list of 14. Findings include: 1.) R8's August 2022 Physician's Orders documents to administer Calcium 600 mg (milligrams) one tablet daily at 9:00 AM. On 8/3/22 at 10:13 AM V10 Licensed Practical Nurse (LPN) obtained one tablet from a white bottle that had R8's name and Calcium 600 mg handwritten on the bottle. This bottle did not contain a pharmacy or over the counter label identifying the medication. V10 entered R8's room to administer R8's morning medications including the Calcium 600 mg. On 8/3/22 at 11:38 AM V3 Assistant Director of Nursing stated: R8's family supplies R8's medications and had removed the label from the calcium bottle. R8's family has been told before that the medications have to have a label. 2.) R9's June 2022 document an order to administer Novolog insulin per sliding scale based on blood sugar results at 7:30 AM, 11:30 AM, 4:30 PM, and 8:30 PM. On 8/3/22 at 10:50 AM V10 obtained R9's blood glucose level of 294. R9 should receive 8 units of Novolog for a blood sugar of 294. On 8/3/22 at 10:53 AM there was a Novolog pen and a vial of Novolog located in the top drawer of the medication cart. The pen was not labeled with a resident's name or an open date. The vial had a handwritten date of 5/20 and was not labeled with a resident's name. V10 stated V10 is unable to verify who the Novolog pen and vial belong to, since the medications aren't labeled with a resident name. On 8/3/22 at 11:03 AM V3 discarded the Novolog pen and vial, and stated the medications are improperly stored. 3.) R11's August 2022 Physician's Orders document Breo Ellipta 200-25 mcg (micrograms) inhale 1 puff by mouth daily at 8:00 AM. On 8/4/22 at 11:44 AM R11's Breo Ellipta inhaler label documented 100-25 mcg, and not 200-25 mcg as ordered. The label did not contain a dispensed date or an opened date. R11's name was handwritten on the inhaler. V4 RN administered Breo Ellipta 100-25 mcg 1 puff to R11. V4 confirmed R11's inhaler did not contain a pharmacy label with a dispensed date, opened date, or name. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Procurement And Storage of Medications policy with a reviewed date of 11/6/18 documents: All medications brought into the Facility shall be labeled with at least the following information: Name, address and phone number of dispensing pharmacy; resident name, physician name, name and strength of medication, directions for administering, last date dispensed and prescription number; both the brand and generic name if substitution is made; appropriate auxiliary labeling. All medication containers shall be labeled with the date opened by the person breaking the container seal.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to obtain and implement laboratory orders for two (R7, R3) of four residents reviewed for laboratory services in the sample list of 14. Findings include: 1.) R7's August 2022 Physician's Orders document R7's diagnoses include gastrointestinal bleed, history of Atrial Fibrillation, Congestive Heart Failure, Chronic Obstructive Pulmonary Disorder, and Diabetes Mellitus. R7's 7/13/22 Admission Physician's Orders document to obtain Complete Blood Count (CBC), Hemoglobin A1C (HgbA1C) every 3 months, and Comprehensive Metabolic Panel (CMP) every 6 months. There is no documentation in R7's medical record of laboratory results since R7 admitted to the facility on [DATE]. On 8/4/22 at 9:11 AM R7 stated R7 has not had any laboratory draws since R7 admitted to the facility on [DATE]. V7 has a history of gastrointestinal bleeding. On 8/4/22 at 11:50 AM V15 Physician stated: V15 doesn't remember being notified by the facility for R7's admission orders. If the facility would have contacted V15, V15 would have ordered a CBC, CMP, and HgbA1C on admission to follow up on R7's anemia and Congestive Heart Failure. 2.) R3's August 2022 Physician's Orders document to obtain HgbA1C, Lipids, CMP, and Magnesium level every 3 months, and R3's diagnoses include Diabetes Mellitus, Hypertension, Anemia, and Chronic Kidney Disease Stage III. R3's laboratory results document a CMP and Lipid Panel were drawn on 2/16/22. There are no other documented CMP, Lipid Panels in R3's medical record. There is no documentation that a HgbA1C or Magnesium level were obtained as ordered between 9/23/21 and 8/4/22. On 8/4/22 at 2:23 PM V2 Director of Nursing stated V2 provided all of R3's and R7's laboratory results requested for the past year. V2 stated V2 expects physician's orders to be followed.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 40385 Based on interview and record review the facility failed to provide therapy services in accordance with the plan of care for three (R3, R7, R11) of three residents reviewed for therapy in the sample list of 14. Findings include: 1.) R3's Physical Therapy (PT) Plan of Care dated 6/28/22 documents Frequency/Duration 5 times a week for 4 weeks. R3's Updated PT Plan of Care dated 7/26/22 documents Frequency/Duration 5 times a week for 4 weeks. R3's PT Daily Treatment Notes from 6/26/22-8/3/22 provided by V20 Director of Therapy, do not document R3 received PT five times weekly during the week of 7/10/22. 2.) R7's PT Plan of Care dated 7/15/22 documents Frequency/Duration 5 times a week for 4 weeks. R7's PT Daily Treatment Notes provided by V20, do not document R7 received PT 5 times during the week of 7/17/22. 3.) R11's PT Plan of Care dated 7/19/22 documents Frequency/Duration 5 times a week for 4 weeks. R11's PT Daily Treatment Notes provided by V20, do not document R11 received PT 5 times during the week of 7/24/22. On 8/3/22 at 12:49 PM V20 stated R7 has been receiving PT since 7/15/22, and PT visits are scheduled 5 days per week. V20 stated R3 and R11 are on PT caseload and PT visits are scheduled for 5 times per week. On 8/3/22 at 3:07 PM V20 stated there have been missed therapy sessions due to a lack of staff. V20 stated the PT Assistant has been on a medical leave, and they have had to borrow therapy staff from other facilities. V20 stated we try to make up the missed visit on another day during the week the visit was missed. therapy department has had some staffing challenges and residents have missed therapy visits in the last few weeks due to a PTA (PT Assistant) being off work on medical leave. On 8/4/22 at 9:35 AM V20 confirmed R3's, R7's, and R11's missed PT visits.