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	09/21/2022

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to ensure staff utilize privacy curtains during personal care. This failure has the potential to affect for four (R31, R15, R72, R33) of four residents reviewed for dignity in the sample list of 47. Findings include: The Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term care Facilities revised November 2018 documents: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. 1.) R72's Minimum Data Set (MDS) dated [DATE] documents R72 has severe cognitive impairment, requires extensive assistance of one staff person for toileting, and R72 is always incontinent of bowel and bladder. On 9/18/22 at 10:27 AM R31 (R72's spouse/roommate) stated: While R15 was visiting in R31's/R72's room yesterday, an unidentified CNA (Certified Nursing Assistant) came in to change R72's incontinence brief and never pulled the privacy curtain during R72's care. R72 was exposed and in R15's view. I've been a CNA and they should pull the privacy curtain. On 9/18/22 at 3:41 PM R15 stated: Yesterday while R15 was visiting R31, an unidentified CNA came into the room, did not pull the privacy curtain, and pulled down R72's pants to check for incontinence. (R31) was pretty upset over it. On 9/18/22 at 3:31 PM V25 Registered Nurse stated R31 is alert and oriented to person, place, and time. On 9/18/22 at 3:46 PM V27 CNA stated R15 is alert and oriented times 4 (person, place, time, and situation.) 2.) On 9/20/22 at 09:20 AM V15 and V32 CNAs entered R33's room and provided catheter care. R33's door remained open and the privacy curtain was not pulled during R33's catheter care. On 9/20/22 at 4:53 PM V2 Director of Nursing stated privacy curtains should be pulled during cares. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Catheter Care policy revised 12/8/10 documents to provide for privacy while performing catheter care.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 34201 Based on interview and record review, the facility failed to accurately assess resident behaviors for one of 47 residents (R14) reviewed for assessments on the sample list of 47. Findings Include: R14's MDS (Minimum Data Set) dated 7/11/22 documents R14 has Diagnoses of: Anxiety Disorder, Depression, Bipolar, and Psychotic Disorder, takes Antipsychotics, Antidepressants and Antianxiety Medications daily and has no mood or behavior problems. R14's Behavior Tracking Sheets February - September 2022 document R14 has multiple episodes of verbal and/or physical outbursts monthly. On 9/18/22 at 8:47 AM, V59 Care Mentor stated R14 has verbal and physical outbursts, explaining when R14 is agitated, R14 gets loud, starts talking to R14's self and will hit R14's self in the face. R14's Hospital Notes dated 5/28/22 document R14 was seen in ER (emergency room) for aggressive behavior. R14's Care Plan dated 7/11/22 documents R14 has a history of displaying inappropriate behavior and/or resisting care/services. Specific behaviors exhibited are yelling outbursts, hitting self, throwing foot tray related to bipolar disorder, depression, anxiety, and psychosis with behaviors. On 9/20/22 at 2:04 PM, V2 DON (Director of Nursing) stated R14 has verbal outbursts. V2 stated V2 has never personally witnessed R14 become physical however V2 has been told that R14 tore off a window shade in R14's former room and caused a lot of structural damage to the room. The facility Comprehensive Assessment/MDS Policy dated 11/1/2017 documents the facility will comprehensively assess and periodically reassess residents who are admitted into the facility. The results of this assessment shall serves as the basis for determining resident strengths, needs, goals, life history and preferences.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Based on interview and record review, the facility failed to complete a baseline care plan for three of five new admission (R182, R79, R278) reviewed for care plans on the sample list of 47. Findings Include: The facility Baseline Care Planning Policy dated 3/16/22 documents the facility will promptly assess and plan care for each resident admitted to the facility. Pending completion of the Comprehensive Resident Assessment and Care Plan, the interdisciplinary team shall assess each resident for potential needs. A Baseline Plan of Care shall be developed to include instructions needed to provide effective person centered care to each resident based on his/her initial assessment and the professional standards of quality of care, to served as a functional guide in delivery of care until such times as a comprehensive plan is developed. The Baseline Care Plan shall be completed within 48 hours of admission. 1.) R182's undated Facesheet documents R182 was admitted to the facility on [DATE]. R182's Nurses Notes dated 9/2/22 document R182 was admitted to the facility per squad. R182 has oxygen connected to R182's tracheostomy at 5 liter and has an indwelling catheter. On 9/19/22 at 10:14 AM V7 MDS (Minimum Data Set)/CP (Care Plan) Coordinator stated the floor/admission nurse is to complete the initial/Baseline care plan for new admissions, it's a two page paper that is kept in the medical record. On 9/19/22 at 10:30 AM, R182's Medical Record did not contain a Baseline Care Plan. On 9/19/22 at 10:52 AM, V3 ADON (Assistant Director of Nursing) stated, if it's not in the chart, it does not exist. 40385 2.) R278's Nursing Notes document R278 admitted to the facility from the hospital on 9/16/22. R278's medical record did not contain a baseline care plan. On 9/19/22 at 11:00 AM V3 Assistant Director of Nursing stated baseline care plans are to be completed on the day of admission. V3 confirmed R278 did not have a baseline care plan in R278's medical record. 3.) R79's closed record provided by V2 Director of Nursing, did not contain a baseline care plan. R79's face sheet documents R79 admitted to the facility on [DATE]. On 9/21/22 at 12:00 PM V5 Social Services stated corporate came into the facility a few months ago and thinned charts. The documents that were thinned are stored in Building 3, and staff are looking for R79's medical records. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide additional records for R79, including a baseline care plan.

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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. 34201 Based on observation and record review, the facility failed to complete a comprehensive care plan for one of 42 residents (R49) reviewed for comprehensive care plans on the sample list of 47. Findings Include: On 9/18/22 at 10:15 AM, R49 was lying in bed with 6 liters of oxygen supplied into R49's tracheostomy tubing attached to R49's neck. R49 had an enteral tube feeding pump with feeding hanging next to R49's bed, that was not connected to R49's feeding tube. R49's September 2022 Physician Orders document Tracheostomy Care is to be completed every shift, but does not specify what type or size of tracheostomy R49 has. These orders also document G-Tube(Gastrostomy Tube) care is to be completed daily but does not mention the type of G-Tube R49 has or specific care instructions. R49's Care Plan dated 8/15/22 documents R49 has impaired expressive communication related tracheostomy placement and that R49 experiences shortness of breath related to diagnosis/condition, which does not contain resident specific information and was left blank. This Care Plan also documents R49 receives Enteral Nutrition support but does not document R49's diagnosis/condition for the need of enteral nutrition, swallow status, size or type of feeding tube, nor type or amount of enteral feeding. The facility Comprehensive Care Planning Policy dated 7/20/22 documents the CCP (Comprehensive Care Plan) shall be developed within seven days of the completion of the Comprehensive Assessment. The CCP shall strive to describe the resident's preferences, choices and goals to the extent possible to assist in attaining or maintaining the resident's highest practicable quality of life, along with the resident's medical, nursing, physical, mental, and psychosocial needs and preferences.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. 40385 Based on observation, interview and record review, the facility failed to ensure qualified staff administered intravenous medication through a peripherally inserted central catheter (PICC) line for one (R278) resident reviewed for intravenous catheters in the sample list of 47. Findings include: The Illinois Department of Financial and Professional Regulation undated notice titled Important Notice Regarding the Administration of IV (Intravenous) Medication by LPNs (Licensed Practical Nurses) documents Applying these above referenced principles, to the LPN who possesses the proper education, training and experience may in fact administer antibiotic medications through a peripheral IV line via IV piggyback for a continuous infusion of fluids, with or without medications, through an IV access device. A peripheral IV line is defined as a short catheter inserted through the skin into a peripheral vein. Antibiotics may also be administered through peripheral access for intermittent infusions. This notice does not document that LPNs can administer medication through central lines. R278's September 2022 Physician's Order Summary documents to change R278's PICC line dressing every 3 days and administer Unasyn (antibiotic) 3 grams intravenously every 6 hours. On 9/19/22 at 12:34 PM V49 Licensed Practical Nurse (LPN) flushed R278's PICC line with 10 ml (milliliters) of Sodium Chloride and administered R278's Unasyn 3 grams via an IV pump set at a rate of 200 ml/hr (milliliters per hour) and duration of 30 minutes. At 1:20 PM V49 disconnected the Unasyn and IV tubing, and flushed R278's PICC line with 10 ml of Sodium Chloride. On 9/19/22 at 4:09 PM V2 Director of Nursing stated in the state of Illinois, LPNs can not administer central line IV medications.

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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 observation, interview, and record review the facility failed to provide timely incontinence care and provide assistance out of bed for two (R33, R69) of four residents reviewed for activities of daily living in the sample list of 47. Findings include: 1.) On 9/18/22 at 7:56 AM R33 was Lying in bed. R33 stated I'd like to get up out of bed every day, but that doesn't always happen. There's only one CNA (Certified Nursing Assistant) that gets me up, and she works tomorrow. On 09/18/22 at 12:53 PM and 4:12 PM R33 was lying in bed. R33's Minimum Data Set (MDS) dated [DATE] documents R33 as cognitively intact and R33 is dependent on two staff for transfers. On 9/20/22 at 12:33 PM V3 Assistant Director of Nursing stated R33 should be gotten out of bed at least daily. 32853 2.) R69's undated Cumulative Diagnosis Log documents diagnoses including Alzheimer's Dementia, Cataract, Dementia Behavior and Psychosis. R69's MDS dated [DATE] documents R69 is totally dependent on one staff person for toileting and documents R69 is always incontinent of bowel and bladder. This MDS documents R69 is severely cognitively impaired. R69's Care Plan dated 1/14/22 documents R69 has an alteration in Bladder Elimination related to incontinence with a goal of being clean, dry and odor free. This Care Plan documents to toilet per schedule and as needed. On 9/18/22 at 12:35 PM, R69 was walking down the hallway and R69's shorts were soaked through, the left side of R69's shirt was wet up the side and the incontinence brief was visibly sagging in R69's shorts. V12 Certified Nursing Assistant walked R69 into R69's room to change R69. V12 pulled down R69's shorts, confirmed they were wet, removed R69's shirts and confirmed it was wet, removed R69's incontinence brief that was saturated with urine and brown stool. V12 stated R69 was last changed at 10:00 AM.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40385 Based on observation, interview, and record review the facility failed to implement orders for peripherally inserted central catheter (PICC) dressing changes and flushes, document insulin administration amounts and injection sites, document blood glucose results and sites, report elevated blood glucose levels to the physician, monitor blood pressure and pulse as ordered, and administer wound treatments as ordered for six (R278, R35, R57, R34, R53, R61) of 19 residents reviewed for quality of care in the sample list of 47. Findings include: 1.) On 9/18/22 at 8:03 AM R278 had a PICC line to the right arm that was covered with a dressing dated 9/16/22. R278 stated R278 admitted to the facility from the hospital on 9/16/22, and R278 receives intravenous antibiotics. On 9/20/22 at 8:40 AM R278's PICC line dressing was dated 9/16/22. R278 stated no one has changed R278's PICC line dressing. On 9/19/22 at 12:34 PM V49 Licensed Practical Nurse (LPN) flushed R278's PICC line with 10 ml (milliliters) of Sodium Chloride prior to administering R278's Unasyn 3 grams. At 1:20 PM V49 disconnected the Unasyn tubing and flushed R278's PICC line with 10 ml of Sodium Chloride. R278's September 2022 Physician's Order Summary documents to change R278's PICC line dressing every 3 days. There are no orders to flush R278's PICC line before and after administering Unasyn (antibiotic). There are no documented measurements of R278's external PICC line or circumference of R278's upper arm. R278's Treatment Administration Record (TAR) dated 9/16/22 does not document R278's PICC line dressing was changed or when it is scheduled to be changed. On 9/20/22 at 4:53 PM V2 Director of Nursing (DON) stated PICC line dressings should be changed every 3 days, and the resident's medical record should include the circumference of arm and length of external catheter. V2 stated usually the hospital sends documentation of the measurements with the resident. On 9/21/22 at 11:07 AM V2 stated: PICC lines should be flushed with 5 ml of Sodium Chloride before and after intravenous medication administration. Heparin should only be used for flushes if ordered by the physician. There should be a flush order on the resident's POS and documented on the MAR (Medication Administration Record). The facility's Central Vascular Access Device Dressing Change policy dated as revised 5/1/16 documents: Change the dressing 24 hours after insertion or upon admission, every two days, and as needed when loose or soiled. Measure the length of the external catheter 24 hours after insertion or upon admission, with dressing changes, if you suspect a change in length, or when signs of complications. For PICCs, obtain upper arm circumference 10 cm (centimeters) above the antecubital fossa upon admission if there are no documented measurements available, weekly, and when signs of complications. Compare to baseline measurement to detect possible catheter-associated venous thrombosis (blood clots); a 3-cm increase in arm circumference and edema were associated with upper-arm deep vein thrombosis. Document the PICC line dressing changes, site assessments, and length of external catheter in the resident's medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Central Vascular Access Device Flushing and Locking policy dated as revised 5/1/16 documents: Specific flush/locking orders must be documented. Flushing/locking is performed to ensure and maintain catheter patency and to prevent the mixing of incompatible medications/solutions. The order must include the flushing/locking agent, strength/concentration, volume, and frequency. 2.) R35's September 2022 POS documents to obtain R35's blood glucose four times daily, give Novolog insulin sub-q (subcutaneously) per sliding scale four times daily, Novolog 17 units sub-q three times daily, and Levemir 8 units sub-q daily at bedtime. The Novolog sliding scale documents to give 10 units for blood glucose greater than 380, and does not include a parameter of when the physician should be notified. R35's August and September 2022 Medication Administration Records (MAR) do not consistently document R35's blood glucose results and sample collection sites, the injection sites for insulin administrations, and the amount of sliding scale insulin administered. R35's August 2022 MAR documents on 8/29/22 at 8:00 PM R35's blood glucose was 421, and on 8/30/22 at 8:00 PM R35's blood glucose was 556. This MAR does not document if Novolog was administered as ordered. There is no documentation in R35's medical record that R35's Physician (V60) was notified of the elevated blood glucose on 8/29/22 and 8/30/22. On 9/20/22 at 4:53 PM V2 DON stated the nurses should be documenting the sites and results of blood glucose tests, amount of insulin given and insulin injection sites on the MAR. On 9/21/22 at 4:00 PM V60 Physician stated the facility should be notifying V60 of blood glucose levels that are outside of the the sliding scale parameters, which is usually greater than 400. V60 confirmed the facility had not reported R35's elevated blood glucose on 8/29/22 and 8/30/22. The facility's Medication Administration policy revised on 11/18/17 documents to record the date, time, drug, dose, and route of medications administered. The facility's Notification for Change in Resident Condition or Status policy revised on 12/7/17 documents to notify the physician of abnormal lab findings, changes in physical condition, and if there is a need to significantly alter the resident's treatment. 38780 3.) R34's Physician Order Sheet (POS) dated 9/1/22 through 9/30/22 documents diagnoses including Diabetes Mellitus, Chronic Kidney Disease Stage 3, and Hypertension. This same POS documents the following orders: Blood pressure and Pulse. Once weekly on Friday and record. Accu-check (blood glucose monitoring). Once daily at 11am and record site and result. Novolog (fast acting insulin) 100 units/ml (milliliter). Inject 8 units Sub-Q (subcutaneous) twice daily with lunch and dinner. Site of injection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Levemir (long acting insulin) Flextouch 100 units/ml. Inject 18 units Sub-Q every bedtime. Site of injection. R34's Medication Administration Record (MAR) dated 9/1/22 through 9/30/22 does not document blood pressure and pulse monitoring on 9/9/22 and 9/16/22; Accu-checks for 9/2/22; complete documentation (missing site, result, or both) for Accu-checks on 9/1/22, 9/3/22 through 9/15/22, 9/17/22 and 9/18/22; Novolog injection sites on 9/3/22, 9/4/22, 9/8/22, 9/9/22, 9/10/22, 9/12/22, 9/13/22, 9/14/22, 9/15/22, 9/17/22, and 9/18/22; or Levemir Flextouch injection sites on 9/1/22 through 9/18/22. R34's Care Plan dated 7/10/22 documents the following: Diabetes- Needs monitored for hyper/hypoglycemic reactions. Resident will maintain accu-check and fasting blood sugar of 60-300 unless otherwise ordered by MD. Administer insulin as ordered. Rotate insulin injection sites. Assess for signs of local irritation at injection site. Monitor blood glucose levels thru capillary checks per MD order. See POS for monitoring frequency, rotate draw site. Notify MD if beyond ordered parameters below 60 and/or above 500. On 9/20/22 at 4:53 PM V2 DON stated the nurses should be documenting the sites and results of blood glucose tests, amount of insulin given and insulin injection sites on the MAR. 4.) R57's Medical Record (current) documents diagnoses including Chronic Kidney Disease Stage 5, Hypoxia, and Fluid Overload. R57's MAR dated 9/8/22 documents an order for Lantus (long acting insulin) 100 units/ml. Give 12 units at night. This same record does not document an injection site for R57's Lantus on 9/8/22 through 9/18/22. R57's Care Plan dated (undated) documents the following: Diabetes-(start date 5/7/22) Resident will maintain accu-check and fasting blood sugar of 60-300 unless otherwise ordered by MD. Insulin Dependent: Administer insulin as ordered. Rotate insulin injection sites. Monitor blood glucose levels thru capillary checks per MD order-See POS for monitoring frequency, rotate draw site. Notify MD if beyond ordered parameters below 60 and/or above 500. There is no documentation in R57's medical record of monitoring R57's blood glucose. On 9/18/22 at 10:04am, R57 stated staff have not been checking R57's blood glucose. R57 stated blood glucose is supposed to be checked three times a day with meals. On 9/20/22 at 12:05pm, V2 DON confirmed there is no order to monitor R57's blood glucose. V2 stated this [missing previous orders] happens when a resident goes out to the hospital, comes back and the order isn't carried over. 32853 5.) R53's Physician Order Sheet (POS) dated 9/1/22 through 9/30/22 documents diagnoses including Parkinson's Disease, Depression, Alzheimer's Disease, CVA (Cerebrovascular Accident), Anxiety and VP (Ventriculoperitoneal) Shunt. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R53's Treatment Administration Record (TAR) dated 8/18/22 documents an order for the left dorsal foot to cleanse with normal saline, apply antibiotic ointment and calcium alginate with silver cover with a gauze bordered dressing and change daily. This treatment started on 8/18/22 and this TAR documents this treatment was not signed out as completed on 8/20/22, 8/21/22, 8/22/22, 8/24/22 through 8/31/22. R53's same TAR documents an order dated 8/18/22 for the right foot plantar to cleanse with normal saline, pat dry, apply medicated honey and calcium alginate, cover with abdominal padded gauze and secure with rolled gauze and change daily. This treatment order started on 8/18/22 and was not signed out as completed on 8/20/22, 8/21/22, 8/22/22, 8/24/22 through 8/31/22. R53's same TAR documents an order dated 8/18/22 for the left outer ankle to cleanse with normal saline, pat dry, apply medicated honey and calcium alginate, cover with gauze island dressing and change daily. This treatment order started on 8/18/22 and this TAR documents this order was not signed out as completed on 8/20/22, 8/21/22, 8/22/22, 8/24/22 through 8/31/22. R53's Treatment Administration Record (TAR) dated 9/8/22 documents a treatment order for the right plantar foot to cleanse with normal saline, pat dry, apply calcium alginate, cover with abdominal padded gauze dressing and change daily. This treatment started on 9/8/22 and is not signed out as completed on 9/9/22 through 9/14/22 and 9/16/22. R53's same TAR documents a treatment order for the left ankle to cleanse with normal saline, pat dry, apply calcium alginate and apply a silicone bordered foam bandage and change daily. This treatment started on 9/8/22 and is not signed out as completed on 9/9/22 through 9/14/22 and 9/16/22. R53's TAR documents progress/comments, wound deteriorated r/t (related to) maceration. (R53) in bed frequently. Pressure relieving boot provided. Measurements documented on this TAR are 1.2 cm (centimeter) x 1.3 cm x 0.1 cm and is documented as a vascular ulcer. On 9/18/22 at 12:58 PM, V3 Assistant Director of Nursing/Wound Nurse removed R53's dressing on the right plantar foot and there was red drainage on the dressing. The wound had a calloused area around the wound and some necrotic tissue to the wound bed. V3 measured the wound as 0.4 cm x 0.4 cm x 0.1 cm then V3 cleaned the wound. V3 then applied the entire 2 inch by 2 inch piece of calcium alginate over the wound and on the healthy tissue, covered with the abdominal padded gauze and rolled gauze. Then V3 removed the dressing from R53's left foot. V3 measured this wound as 1.1 cm x 0.8 cm. After V3 cleaned the wound, V3 applied the entire 2 inch by 2 inch piece of calcium alginate over the wound and on healthy tissue and covered with a bordered foam dressing. On 9/21/22 at 12:11 PM, V2 Director of Nursing stated that nurse's should initial in the box on the TAR when a treatment has been completed. V2 stated if the box is not initialed it appears that the treatment was not completed. On 9/21/22 at 1:07 PM, V2 Director of Nursing stated calcium alginate should be cut to the size of the wound and should not be placed on healthy tissue or eschar. 6.) R61's POS dated 7/1/22 through 7/31/22 documents diagnoses including Dementia and Diabetes. (continued on next page)

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	145389	A. Building B. Wing	09/21/2022

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R61's Treatment Administration Record (TAR) dated 9/1/22 through 9/30/22 documents an order dated 9/8/22 for the right lower extremity to cleanse with normal saline, pat dry, apply calcium alginate, cover with an abdominal padded gauze, wrap with rolled gauze and change daily and as needed. This TAR documents this treatment was not signed out as completed on 9/9/22 through 9/17/22. On 9/18/22 at 12:55 PM, R61 stated that R61 was worried about R61's wound because the bandage has not been changed in more than five days. R61 stated that R61 has gotten the bandage wet with urine and it was not changed. On 9/18/22 at 1:24 PM, R61 stated R61's wound is hurting something fierce. V3 Wound Nurse confirmed there was not date written on the dressing to indicate when it was last changed. V3 confirmed the dressing is supposed to be changed daily.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to administer pressure ulcer treatments, implement pressure relieving interventions and implement nutritional recommendations for one (R33) resident reviewed for pressure ulcers in the sample list of 47. Findings include: R33's Minimum Data Set, dated dated dated [DATE] documents R33 has a stage II pressure ulcer that was not present upon admission or reentry to the facility. R33's Care Plan dated 3/10/21 documents R33 has a history of a pressure ulcer of the right distal medial foot and right medial heel. R33's September 2022 Physician Orders Summary (POS) document Prostat (protein supplement) give 30 ml (milliliters) twice daily, foam boots on at all times to bilateral lower extremities, and cleanse R33's coccyx wound with normal saline, dry, and apply a bordered foam dressing every 3 days. This POS lists Prostat under dietary orders, and does not schedule Prostat to be administered as part of medication administration. R33's August and September 2022 Treatment Administration Records (TAR) do not document R33's coccyx wound treatment was administered as ordered five times, or that R33's pressure relieving boots are regularly implemented twice daily as scheduled. R33's September TAR documents: On 9/8/22 R33's coccyx Stage III pressure ulcer measured 3.5 cm (centimeters) long by 3 cm wide by 0.1 cm deep. On 9/19/22 R33's coccyx stage III pressure ulcer measured 2.5 cm by 2.1 cm by 0.1 cm deep. On 9/20/22 at 9:27 AM V49 Licensed Practical Nurse administered R33's coccyx wound treatment. There were 3 small superficial open areas to R33's coccyx. R33 was wearing a foam boot only on the right heel. On 9/20/22 at 12:33 PM V3 Assistant Director of Nursing stated: R33 should be wearing pressure relieving boots to bilateral feet, and pressure relieving boots are documented on the TAR. Prostat should be documented on the MAR and administered by the nurse.

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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 securely store an oxygen cylinder, complete fall risk assessments, complete post fall neurological assessments, investigate a fall to identify the root cause, and ensure a bed had functioning brakes for three (R42, R72, R278) of six residents reviewed for accidents in the sample list of 47. Findings include: 1.) On 9/18/22 at 9:45 AM there was an oxygen cylinder in R42's room that was freestanding and not stored securely. On 9/19/22 at 8:20 AM V49 Licensed Practical Nurse entered R42's room. V49 picked up R42's oxygen cylinder that was freestanding, and placed the cylinder into a bag on the back of R42's wheelchair. On 9/20/22 at 4:53 PM V2 Director of Nursing (DON) stated oxygen cylinders should be stored in a bag on the back of the wheelchair, and confirmed the cylinders should not be free standing/unsecured. The facility's Oxygen Cylinders policy revised 3/29/19 documents: Secure the oxygen cylinder by using one of the following methods: 1. Chained stand 2. Oxygen cart 3. Donut/oxygen rack 4. Wheelchair bracket. Cylinders must be stored in racks, carts, wheelchair brackets or behind chains: cylinders are never to be left freestanding. 2.) R72's Minimum Data Set, dated dated dated [DATE] documents R72 has severe cognitive impairment, requires extensive assistance of one staff person for toileting, and R72 is always incontinent of bowel and bladder. R72's Care Plan dated 8/8/22 documents R72 is at high risk for falls and includes an intervention dated 9/11/22 for frequent wellness checks. R72's September 2022 Physician's Orders document administer Eliquis (anticoagulant) 5 mg (milligrams) by mouth twice daily. R72's nursing note dated 9/11/22 at 5:15 AM documents R72 was found lying on the floor on R72's stomach. R72 had a skin tear to the left elbow and left great toe. R72 was transferred to the local emergency room . There are no documented post fall assessments or neurological assessments following R72's fall. On 9/18/22 at 10:27 AM R31 (R72's spouse/roommate) stated R72 doesn't get changed as often as R72 should, and sometimes R72 will go without incontinence care for 4 hours or longer. R31 stated R31 was hospitalized a few days ago after falling out of bed. R72 messed up R72's knee and arm. R72 is determined to get up to the bathroom, but R72 can't walk. On 9/21/22 at 9:58 AM V2 DON stated V2 was not able to locate R72's 9/11/22 fall investigation/packet, and the nurses are to complete a fall packet whenever there is a fall. V2 stated post fall neurological assessments are to be completed for witnessed and unwitnessed falls when the resident is on an anticoagulant, and should be documented on the neurological assessment form and placed in the resident's medical record. V2 confirmed there were no documented post fall neurological assessments in R72's medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) On 9/18/22 at 8:03 AM R278 was sitting up in bed. R278 stated R278's bed does not lock and moves all over the place when R278 tries to get out of bed, or when staff provide R278's care. There were no brakes observed on R278's bed. R278's medical record documents R278 admitted to the facility on [DATE], and does not document a fall risk assessment was completed. On 9/18/22 at 2:30 PM PM V50 Certified Nursing Assistant entered R278's room, and moved R278's bed freely away from the wall without disengaging any brakes. V50 confirmed there were no brakes on R278's bed. At 2:38 PM V3 Assistant Director of Nursing (ADON) confirmed R278's bed did not contain brakes for the wheels. V3 stated V3 will have V6 Maintenance get R278 a different bed. On 9/19/22 at 11:00 AM V3 ADON confirmed R278's admission fall risk assessment was incomplete. At 11:11 AM V3 stated assessments should be completed on admission, and the nurses are not suppose to leave until all of the assessments are completed. The facility's Fall Prevention policy revised 11/10/18 documents: Assessments of Fall Risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM (Assess Intervene Monitor) for Wellness form along with any new intervention deemed to be appropriate at the time. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to obtain and implement urinary catheter orders, assess for the use of a catheter, secure urinary catheter tubing, correctly perform catheter care and properly store a urinary catheter drainage bag for two (R33, R182) of two residents reviewed for urinary catheters in the sample list of 47. Findings include: The facility's Catheter Care policy reviewed February 2018 documents Catheter care is provided daily and as needed to all residents who have an indwelling catheter to reduce the incidence of infection. For males wash around the urinary meatus, wash the catheter tubing from the urethral opening outward approximately 4 inches. This policy does not document how to handle or store urinary catheter bags. 1.) On 9/18/22 at 12:46 PM R33 stated: Only certain CNAs (Certified Nursing Assistants) provide urinary catheter care, and the care is not performed on a daily basis. R33's catheter is suppose to be changed monthly by the facility, and the catheter was last changed in July 2022. The facility told R33 that they do not have catheters in stock, because staff have not been keeping up with ordering the catheters. On 9/20/22 09:20 AM V15 and V32 CNAs entered R33's room to provide catheter care. R33 was lying in bed and R33's urinary catheter tubing was not secured to R33's leg. V32 used a washcloth to wipe around R33's urinary meatus several times, folded the cloth and wiped down the urinary tubing. V32 folded the cloth again and used the same area of the cloth to clean R33's urinary meatus, penis, and R33's catheter tubing. On 9/20/22 at 9:27 AM V49 Licensed Practical Nurse entered R33's room to administer R33's wound treatment. R33 was lying in bed and turned onto R33's side. V49 lifted R33's urinary catheter drainage bag above R33's bladder to move the bag to the other side of the bed, causing urine in the tubing to move back towards R33's bladder. R33's urine was clear yellow and had white sediment in the tubing. R33's Care Plan dated 3/10/21 documents R33 has a urinary catheter and a history of urinary tract infections, and includes interventions to keep the drainage bag below bladder level to prevent reflux, secure the catheter to R33's leg to avoid tension on the urinary meatus, administer catheter care twice daily, and change the catheter as ordered. R33's August 2022 Physician's Orders Summary documents to change R33's urinary catheter and drainage bag monthly, and complete catheter care every shift. R33's August and September 2022 Treatment Administration Records (TARs) do not document that R33's urinary catheter was changed or that catheter care is completed every shift as ordered. On 9/19/22 at 10:28 AM V3 Assistant Director of Nursing stated catheter care is performed by the CNAs and recorded by the nurse twice daily on the TAR. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/20/22 at 3:52 PM V1 Administrator stated the catheter care policy provided is the only catheter policy V1 could locate. On 9/20/22 at 4:12 PM V2 Director of Nursing stated catheters are to be changed monthly and recorded on the TAR. At 4:53 PM V2 stated: The urinary catheter collection bag should be positioned below the level of the bladder. Staff should use a clean cloth or clean area of a cloth when cleansing the catheter tubing. Some CNAs don't realize they can't just continue the motion from cleansing the penis and then down the catheter tubing. 34201 2.) R182's Nursing Progress Notes documents R182 was admitted to the facility on [DATE] with an indwelling catheter. R182's September 2022 Physician Orders document indwelling catheter care is to be completed every shift however there are no other catheter orders such as the catheter/balloon size, when/how often the indwelling catheter should be changed, or a diagnosis for the indwelling catheter. On 9/18/22 at 9:35 AM, R182's catheter tubing was not secured to R182's leg. On 9/18/22 at 1:26 PM, R182's catheter bag was sitting inside of a garbage can, that contained garbage. R182's medical record did not contain an indwelling catheter assessment on 9/18/22 - 9/20/22. On 9/20/22 at 2:09 PM, V2 DON (Director of Nursing) stated catheter assessments are to be completed upon admission and staff need to ensure there is an order for the catheter with specifics of size, when changed and how often catheter care should be completed. V2 also stated V2 normally makes sure residents have a proper diagnosis for the catheter but V2 hasn't gotten to it yet. V2 stated the catheter drainage bag should not have been in the garbage can and that the catheter tubing should be secured to prevent the catheter from being pulled out but we {facility} don't have any securement straps at this time.

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F 0692 Level of Harm - Minimal harm or potential for 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** 40385 Based on observation, interview, and record review the facility failed to identify and evaluate a significant weight loss, record weights, provide therapeutic and prescribed diets, complete nutritional evaluations by a dietitian, and implement nutritional interventions for three (R11, R35, R42) of six residents reviewed for nutrition in the sample list of 47. Findings include: The facility's Resident Weight Monitoring policy dated September 2008 documents: Residents should be weighed by the 10th of each month and recorded on the Report of Monthly weight form in the resident's medical record. The resident, family, physician, and dietitian will be notified of significant weight losses (5% or more in 1 month, 7.5 % or more in 3 months, or 10 % or more in 6 months). The dietary manager and dietitian review residents' nutritional status and make recommendations for nutritional interventions. Nursing is responsible for notifying the physician and obtaining orders for the nutritional recommendations. The Weight Committee will identify changes in weights and the care plan will include significant weight loss and interventions. 1.) The facility's Weight Grid dated October 2021-September 2022 documents R11's weights as 160.6 lbs (pounds) in April, 172.8 in May, none recorded for June and July, and 154.4 lbs in August and September (10.65% loss in 3 months). The only documented weight in R11's medical record is 157 lbs. in January 2022. R11's September 2022 Physician's Order Summary (POS) documents R11's diet includes carbohydrate controlled and double protein at breakfast and lunch. R11's Care Plan dated 7/11/22 documents R11 needs double protein at breakfast and lunch and does not address R11's recent significant weight loss. V47 (Registered Dietitian) Consultant Dietitian Reports dated 6/25/22, 7/16/22 and 8/13/22 do not document that V47 has evaluated R11's weight/nutrition. There is no documentation in R11's medical record that R11's weight loss was identified and evaluated by a physician, or that new nutritional interventions were implemented after the weight loss. On 09/18/22 8:40 AM R11 was lying in bed. R11 stated R11 has had weight loss, but was unsure the amount of weight loss or what the facility was doing to maintain R11's weight. R11 stated R11 does not receive any nutritional supplements. On 9/20/22 at 8:50 AM R11 was served a biscuit with sausage gravy, oatmeal, milk, and orange juice. R11's meal card does not document double protein at breakfast and lunch. On 9/20/22 at 12:53 PM V10 Dietary Manager confirmed the facility's weight report does not document R11's weights in June and July. V10 stated: V10 was not sure what attributed to R11's weight loss, and R11 has not been evaluated by V47 since May. Diets are recorded on the meal cards. V10 confirmed R11's meal tray card does not document double protein for two meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/20/22 at 4:53 PM V2 Director of Nursing (DON) stated V2 was not aware that R11 had a significant weight loss. V2 confirmed R11's weight loss was not reported to or evaluated by a physician, and there were no new nutritional interventions implemented. V2 stated: Residents should be evaluated by V47 upon admission, quarterly, and with any changes in condition. 2.) On 9/19/22 at 1:00 PM R35 stated R35 recently started dialysis in August 2022, and R35 was suppose to be on a low sodium diet and watching R35's fluid intake. R35 stated R35 is not on any special renal diet other than R35 is suppose to avoid bananas, and the facility serves R35 bananas. R35 stated R35 has not seen a facility dietitian since R35 admitted to the facility in April 2022. R35's noon meal tray contained mashed potatoes with gravy and country fried steak. R35's meal card documents R35's diet as regular, no added salt, and carbohydrate controlled. The facility's week 4 menu documents the noon meal on 9/19/22 was country fried steak, mashed potatoes with gravy, broccoli, roll with margarine, and frosted cake. R35's Minimum Data Set (MDS) dated [DATE] documents R35 is cognitively intact. R35's Care Plan dated 8/18/22 documents R35 receives dialysis three times weekly for fluid overload. Interventions include to refer to R35's physician's orders for diet and fluid restrictions, record intake and output, encourage compliance and provide education. This care plan does not document that R35 is on a fluid restriction or any foods that R35 should avoid. R35's August and September 2022 POS document: R35 has diagnosis of Congestive Heart Failure, End Stage Renal Disease, and Diabetes Mellitus. R35's diet is no added salt, renal, and heart healthy. There is no documentation in R35's medical record that a nutritional assessment was completed by a dietitian since R35 admitted to the facility in April 2022. There is no documentation of communication and coordination of care with the dialysis center regarding R35's diet or that R35 is on a fluid restriction. On 9/19/22 at 3:29 PM V3 Assistant Director of Nursing (ADON) was unable to provide documentation that R35 was evaluated by V47 Registered Dietitian. V3 stated V47 probably hasn't evaluated R35, since R35 has been in and out of the hospital. On 9/20/22 at 12:53 PM V10 Dietary Manager stated V47 has not evaluated R35 since R35 admitted to the facility. The facility does not have a special diet for residents who receive dialysis. R35 is on a regular and diabetic diet. Residents who receive dialysis should avoid bananas, orange juice, potatoes, and tomatoes. This should be noted on the resident's meal card. V10 confirmed R35's meal card does not document to avoid certain foods or a fluid restriction. On 9/20/22 at 2:00 PM V47 RD stated: V47 visits the facility for two days each month, and V47 was unsure if V47 had evaluated R35. V47 did not recognize V35's name. V47 stated a dialysis patient's diet depends on the dialysis center and how well controlled the resident is. If the resident is well controlled, then it is ok for the resident to have a regular diet while avoiding orange juice, oranges, potatoes, and tomatoes with potassium restrictions. The resident's diet should be coordinated with the dialysis center's dietitian. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/20/22 at 4:53 PM V2 DON stated the dialysis center has not been sending documentation consistently, and usually residents who receive dialysis are to avoid tomatoes, potatoes, and bananas. On 9/21/22 at 12:40 PM V58 (dialysis center dietitian) stated R35's diet should be low phosphorous, 3,000 calorie, 2,000 mg (milligrams) sodium, 2,000 mg potassium, and 1,000 mg phosphate and include a fluid restriction of 1, 000 milliliters per day. 3.) The facility's Weight Grid dated October 2021-September 2022 does not list R42 and R42's weights. R42's weights are not consistently documented at least each month in R42's medical record. R42's Request for Diet Change dated 7/16/22 documents R42 recently readmitted to the facility with End Stage Renal Disease and routine dialysis. R42's overall meal intakes are poor, R42 is showing weight loss, and R42's weight is 110 lbs. V47 RD recommended adding a nutritional supplement 60 cc (Cubic Centimeters) BID (twice daily). R42's Request for Diet Change dated 8/13/22 documents R42's August weight is pending, and please follow up on request to add 60 cc (nutritional supplement) BID. R42's August and September 2022 POS do not document that V47's recommendation for the nutritional supplement was implemented. On 9/20/22 at 12:53 PM V10 Dietary Manager confirmed R42's weights are not recorded on the facility's weight report. V10 stated: Nutritional supplements are administered by the nurses. V47 sends V47's recommendations to V2 DON and V10. Nursing is responsible for following up on V47's recommendations. On 9/20/22 at 2:00 PM V47 RD stated V47's recommendations are given to the facility the same day as V47's visit or by the next day. V47 expects V47's recommendations to be implemented within 48-72 hours. On 9/20/22 at 4:53 PM V2 DON stated: The certified nursing assistants are responsible for obtaining weights. V2 thinks that weights were previously recorded on paper, given to V3 Assistant Director of Nursing, and the weights were never recorded in the charts. (Nutritional Supplement) is recorded on the POS and Medication Administration Record. V2 did not receive V47's recommendations from August 2022.

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 34201 Based on observation, interview and record review, the facility failed to follow registered dietician recommendations and physician orders for enteral nutrition and weekly weights for one of two resident (R49) reviewed for enteral nutrition(tube feeding) on the sample list of 47. This failure resulted in R49 sustaining a 9.10% weight loss in one month and put R49 at risk for aspiration pneumonia. Findings Include: R49's MDS (Minimum Data Set) dated 8/8/22 documents R49 is alert and oriented, independent with decision making and has a Gastrostomy Tube. R49's Request for Diet Change dated 6/6/22 by V47 RD (Registered Dietician) documents R49 remains on tube feeding and flush as ordered with no tolerance concerns noted. Requested to evaluate change in feeding schedule to allow for therapy. At this time, will suggest to change tube feeding and flush to 2 Cal HN at 50 ml (milliliter) per hour for 17 hours with flush to stay at 250 ml water every six hours. This request was accepted by V60 Physician. Please monitor weights weekly and monitor tolerance with increased rate. It does not document what hours R49's enteral nutrition should be ran. R49's Physician Orders dated September 2022 document's R49 is NPO (meaning nothing by mouth) but may have ice chips at bedside, one at a time with nursing or speech therapy present. These orders do not document what hours R49's enteral nutrition should be ran. R49's Interdisciplinary Resident Screen dated 9/12/22 by V45 Regional ST (Speech Therapy) documents a bedside swallow evaluation is not appropriate at this time due to R49 being NPO secondary to pharyngeal dysphagia. Tracheostomy and Gastrostomy Tube in place. A video swallow study is warranted to safely assess R49's swallowing. The facility weight log documents the following weights for R49: August 2022 - 147.2 pounds, September - 133.8 pounds. This calculates to a 9.10% weight loss between August and September {1 month}. R49's MAR (Medication Administration Record) for June, July and September 2022 do not document R49's ordered weekly weight. R49's August 2022 MAR was not in R49's medical record nor provided by V2 DON (Director of Nursing) upon request. R49's Medical Record does not contain any Intake/Output tracking or Enteral Flow Record to document the amount of enteral nutrition received each day. On 9/18/22 at 7:53 AM, R49 was lying in bed, without enteral feeding running, eating a popsicle. No staff were present. A sign hanging on the wall above R49's head of bed that reads R49 is NPO. On 9/18/22 at 10:07 AM, R49 stated R49's enteral feeding runs a couple hours a day. On 9/19/22 at 8:57 AM, R49 was lying in bed without enteral feeding running. (continued on next page)

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	145389	A. Building B. Wing	09/21/2022

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 0693 Level of Harm - Actual harm Residents Affected - Few	On 9/19/22 at 1:27 PM V20 RN (Registered Nurse) entered R49's room and delivered a cup of italian ice {frozen dessert in pre-packaged cup} to R49 stating R49 can have items that melt like italian ice, freeze pops and ice chips but that R49 doesn't eat food. The sign remained above R49's bed documenting R49 is NPO. R49's enteral feeding was not running. R49 started eating the italian ice and V20 left the room, leaving R49 alone. On 9/19/22 at 1:52 PM, R49 was holding the empty italian ice container and stated R49 ate it all. On 9/19/22 at 2:00 PM, R49 was at the Nurses Station requesting hot chocolate. V20 RN stated V20 would have to check and see if R49 could have it. At this time, V8 Activity Director walked by and stated V8 could get R49 some. On 9/19/22 at 2:10 PM, R49 was lying in bed with V20 present as V20 was providing cares. The sign documenting R49 is NPO was still on the wall above R49's bed. V8 brought a cup of hot chocolate into R49's room and left it on the bedside table for R49, and V20 did not instruct V8 that R49 could not have liquids. R49's enteral nutrition was not running. At this time, V20 stated R49's enteral feeding is to run from 1:00 pm - 6 am. V20 completed cares on R49 and left the room. On 9/19/22 at 2:53 PM, R49's cup of hot chocolate was empty. R49 stated I (R49) drank it all. On 9/19/22 at 3:29 PM, R49 was lying in bed and enteral feeding was not running. On 9/20/22 at 9:18 AM, V3 ADON (Assistant Director of Nursing) stated V3 was not able to find any Intake/Output documentation for R49. On 9/20/22 at 9:31 AM, V8 Activity Director stated V8 was not aware R49 was NPO explaining, V8 was just trying to help as V8 heard R49 requesting hot chocolate. V8 stated V8 had observed R49 drinking hot chocolate again later in the day. On 9/20/22 at 10:01 AM, V2 DON (Director of Nursing) stated prior to V2 starting at the facility, the floor staff had decided that popsicles were okay for R49 to have, because it was kind of like ice but R49 should not have had the italian ice or hot chocolate. On 9/20/22 at 1:36 PM, V45 Regional ST stated V45 does not know where R49's original order for NPO with ice chips only if nursing or ST were present came from because R49 hasn't been seen by ST at the facility but based on R49's complexity, V45 thinks it was an order based off of a prior video swallow test. V45 stated popsicles and italian ice are not in the same category as ice chips, explaining they would all be considered a thin liquid but the popcile and italian ice would not be a small amount and that hot chocolate would not be acceptable for R49 either; unless the physician said that was okay, it would not be okay to give it. V45 stated when V45 got the recommendation for a swallow evaluation, V45 didn't feel it would be safe to evaluate R49 without a video swallow because you can't see exactly what is going on without the video and (R49) has difficulty swallowing. V45 explained R49 could aspirate of popciles, italian ice and hot chocolate leading to aspiration pneumonia. On 9/21/22 at 2:28 PM, V47 RD stated without having access to R49's chart for review, V47 does not know what would cause R49's weight loss however it is theoretically possible that without the facility following physician orders of the amount of feeding R49 is to receive, R49 could loose weight. The enteral feeding needs that I (V47) have calculated are what (R49) needs to maintain (R49's) weight as R49 is NPO. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	The facility Enteral Feedings Policy dated February 2008 documents enteral feedings will be provided when it has been determined that oral feedings are not sufficient to meet the physical requirements and the resident/responsible party and physician deem enteral nutritional support is appropriate. The Dietician/Consultant will monitor all diet orders for tube feedings and will recommend as appropriate changes in product according to resident needs. This policy includes a Enteral Flow Record that is to be completed each day that documents the time the feeding started, rate, and shift total of infusion.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34201 Based on observation, interview and record review, the facility failed to obtain and/or follow orders for tracheotomy care, perform hand hygiene to prevent contamination during tracheostomy care, ensure extra tracheostomy tubes and supplies were at bedside and in working order, and failed to date and change oxygen tubing for six of 6 residents (R11, R49, R57, R72, R42 and R182) reviewed for respiratory care on the sample list of 47. These failures resulted in psychosocial harm to R182 when the oxygen tubing became disconnected from the tracheostomy tubing, causing R182 to panic due to being scared R182 was not going to be able to breath. Findings Include: The facility Tracheotomy Care Policy dated 3/29/2019 documents trach (tracheostomy) care should be performed, once per shift or as often as required to maintain patency of the airway and minimize the risk of infection. When the trach tube is fenestrated, inner cannula is to be in place during suctioning or bagging. A replacement trach tube is to be kept at the head of the bed at all times, clearly visible. When providing trach cares: obtain a new trach kit, suction the resident if needed, remove the old trach dressing, open the new kit, obtain the proper size inner cannula and open package, remove oxygen source, unlock, remove and discard the disposable inner cannula, replace inner cannula with sterile disposable inner cannula and replace the appropriate oxygen source, all while using Universal Precautions. With a sterile swab and sterile water and/or 1/4 to 1/2 strength hydrogen peroxide solution, cleanse the area immediately adjacent to the stoma and the base of the trach tube. Take extra precaution not to allow solution to enter the stoma. With a gauze 4 by 4 soaked in sterile water, rinse the area just cleaned. Dry the stoma area with a gauze 4 by 4. Replace sponge behind the trach plate and replace oxygen. To change the neck ties/collars: thread the long narrow fastener tabs through the flanges on the trach tube, bringing it back over the flange and adhere it to the soft material on the band. 1.) R182's Nursing Progress Notes dated 9/2/22 document R182 was admitted to the facility with a tracheostomy present and 5 liters of oxygen being bled into it. On 9/20/22 at 2:29 PM, V2 DON (Director of Nursing) stated trach care is to be completed twice a day. If they are admitted without orders, the admitting nurse should call and get orders, specific to the resident. Care consists of removing the inner cannula and cleaning it or if it has disposable inner cannula, replacing it, cleaning around the site and changing the collar. There should be an extra trach at the bedside. V2 stated R182's neck is too big and our trach collars aren't big enough to go around it. V2 explained the contract RT (Respiratory Therapy) company uses came to evaluate R182 three or four days after admission and ordered supplies but they haven't came in yet. V2 also stated the facility does not have an extra trach for R182. V2 explained V46 (R182's family) was to bring it in but didn't. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On 9/21/22 at 10:02 AM R182 was lying in bed with oxygen being bled into R182's trach. The oxygen tubing was not dated and there was no extra trach at R182's bedside. R182 stated, V182 does not feel the facility provides trach care as often as they should, they only do it when I ask. R182 also stated the facility does not have an extra trach for R182 or the right trach collar, therefore it has not been changed since admission. R182's white trach collar was discolored with a brown substance around the insertion site/stoma. R182's also stated R182 had a problem with the oxygen humidifier tubing that is bled into R182's tracheostomy tubing; it had popped off during the night, a few days prior. R182 stated R182 put R182's the call light on and it took staff over 30 minutes to get to R182. R182 explained R182 was banging R182's cup on the overbed table to try and get staff's attention. R182 further explained, I'm (R182) new to having a tracheostomy and was very concerned. I (R182) was scared that I (R182) wasn't going to be able to breath and started to panic. R182 stated since staff were not answering R182's call light, R182 called V46 (R182's Family) and requested for V46 to call the facility to summons help. R182's September 2022 Physician Orders do not document any orders for tracheostomy care; how often cares should be completed including cleaning and suctioning or the type and size of tracheostomy. R182's TAR (Treatment Administration Record) dated September 2022 does not document when trach care has been provided. On 9/21/22 at 10:57 AM, V20 RN (Registered Nurse) performed trach care on R182 using distilled water. The old 4 by 4 gauze had a moderate amount of yellowish/brownish secretions on it. V20 did not change out the soiled trach collar. On 9/21/22 at 11:02 am, V46 confirmed that on 12/16/22 around 12:30 am - 1:00 am, one of R182's tubes from the trach to the Oxygen had fallen out and R182 used the call light for help, but nobody was coming so R182 had video called V46 asking V46 to call the facility and ask for help. (R182) was starting to panic. I (V46) called the facility and nobody answered. I (V46) then called (R182) back and (R182) said nobody had came in {to R182's room}. We {V46 and R182} went back and forth like that for 20 minutes and still no answer. I (V46) was calling (R182) back to tell (R182), just to call 911 because (R182) was so scared when I (V46) got a text from (R182) saying staff finally came in. 2.) R49's September 2022 Physician Orders documents an order for trach (tracheostomy) care every shift, oxygen at 35% to maintain oxygen saturation above 92%, and to change the trach once a month. On 9/18/22 at 7:53 AM, there was no extra trach visible at R49's bedside. On 9/18/22 at 10:15 AM, R49 was lying in bed with oxygen being bled into R49's trach at six liters. The oxygen tubing was not dated. On 9/19/22 at 1:25 PM, R49 stated staff only complete trach care and suctioning every few days. R49 also stated staff have changed R49's trach once, a long time ago. Humidifier on humidified oxygen running into trach was empty. R49's MDS (Minimum Data Set) dated 8/8/22 documents R49 is alert and oriented. R49's TAR (Treatment Administration Record) dated May 2022 - September 2022 does not document R49's trach was changed monthly as ordered or that trach care is completed every shift as ordered. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On 9/19/22 at 2:09 PM, V20 RN (Registered Nurse) entered R49's room to perform trach care. V20 stated R49's extra trach and down sized trach should be hanging on the wall but it isn't there. V20 checked all of R49's drawers in R49's room and couldn't find the extra trach. At this time, V20 stated R49's oxygen should be humidified and confirmed the humidifier was empty. V20 set up trach care supplies on the overbed table with a hand towel on it. V20 did not disinfect the table prior to setting up the supplies and did not change out the hand towel. V20 then grabbed an open, undated bottle of normal saline from R49's bedside table, that was 3/4 used. V20 opened the trach cleaning tray, applied left sterile glove, opened used normal saline bottle with V20's right hand then placed it on the hand towel. V20 then applied the right sterile glove, picked up the normal saline and poured it into the cleaning tray (with sterile gloves on). V20 dipped the sterile applicator into the normal saline and cleansed around the trach insertion site. V20 then took a pipette and dipped it into the normal saline and cleaned around the hard plastic flange of trach stating, these are normally used to clean the inner cannula but (R49) gets so much build up around the trach, I (V20) like to use it to clean it off. V20s scrubbed the flange around the trach and cleansed off a moderate amount of dark brown crusted substance. V20 then stated V20 was done with trach cares. When asked about cleaning the inner cannula, V20 stated it was replaced last week when RT (Respiratory Therapy) was at the facility so there was no need to clean it. On 9/20/22 at 2:29 PM, V2 DON (Director of Nursing) stated trach care is to be completed twice a day. Care consists of removing the inner cannula and cleaning it or if it's a disposable, replacing it, cleaning around the site and changing the collar. There should be an extra trach at the bedside. 40385 3.) On 09/18/22 at 8:34 AM R11 was lying in bed wearing oxygen at 2 L (liters)/Minute per nasal cannula. The oxygen tubing was not labeled with a date. The refillable humidification bottle was dated 6/1/22. On 9/20/22 at 8:26 AM R11 was lying in bed wearing oxygen at 2 L/minute. There was no date on the tubing. R11's September 2022 Physician's Orders Summary (POS) documents to change R11's oxygen tubing weekly. R11's August and September 2022 Treatment Administration Records (TARs) only document R11's oxygen tubing was changed once between 8/1 and 9/20/22. On 9/20/22 at 4:53 PM V2 Director of Nursing stated oxygen tubing should be changed weekly and recorded on the TAR, and should be labeled with a date. 4.) On 09/18/22 at 9:45 AM R42 was lying in bed wearing oxygen at 2.5 L/minute per nasal cannula. There was no date labeled on the tubing or refillable humidification bottle. R42's September 2022 POS does not include orders for oxygen or to change the oxygen tubing regularly. R42's August and September TARs do not document a schedule for changing R42's oxygen tubing, or administration of oxygen. R42's Nursing notes document R42 used oxygen periodically in June, July, August, and September. R42's Hospital Discharge Orders dated 6/23/22 documents R42 was diagnosed with Pneumonia and treated with antibiotics. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	5.) On 9/18/22 at 9:26 AM and on 9/20/22 at 9:00 AM R72 was lying in bed wearing oxygen at 3 L/minute per nasal cannula. The oxygen tubing was not labeled with a date, and the refillable humidification bottle was dated 6/1/22. R72's Care Plan dated 8/8/22 documents R72 uses inhalers and oxygen as needed with interventions to administer oxygen as ordered. R72's September 2022 POS documents to administer oxygen at 2 L/minute per nasal cannula as needed, and to change the oxygen tubing weekly on Saturdays. R72's TAR documents R72's oxygen tubing was changed once between 8/6/22 and 9/20/22. 38780 6.) R57's Physician Order Sheet (POS) dated 9/1/22 through 9/30/22 documents diagnoses including Chronic Kidney Disease Stage 5, Hypoxia, and Fluid Overload. The same POS does not document any orders for oxygen. On 9/18/22 at 10:06am, R57's was resting in bed with 4 liters of oxygen continuously supplied via nasal cannula and an oxygen concentrator. The oxygen tubing was not dated. R57 stated staff do not change R57's oxygen tubing and R57 usually wears oxygen at night. On 9/20/22 at 10:10am, R57's was resting in bed with 4 with liters of oxygen continuously supplied via nasal cannula and an oxygen concentrator. The oxygen tubing remained undated. R57 confirmed that the oxygen tubing had not been changed at this time. R57's Hospital Pulmonary Progress Note dated 9/8/22 documents: Plan: Can discharge home with supplemental oxygen PRN (as needed) to maintain O2 (oxygen) saturation >90%. R57's Care Plan does not document a focused care area or parameters for R57's oxygen use. R57's Treatment Record (September 2022) fails to document any oxygen tubing changes or humidifier bottle changes for R57. The facility Oxygen Therapy Policy (August 2003) documents: Oxygen therapy may be used provided there is a written order by the physician. The order must state liter flow per minute, mask or cannula, time frame. Change oxygen tubing/mask/cannula/and/or tracheostomy mask on a weekly basis. Date tubing changes and document on the treatment sheet. If humidification is indicated, date prefilled bottles when changed. If using unfilled humidifier bottles; empty, rinse and refill daily with distilled water, and wash with soap and water as needed. Humidifier changes and cleaning is to be documented on the treatment sheet at the time of occurrence.

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to have an active contract with a dialysis center, regularly communicate with the dialysis center to coordinate care, and assess dialysis access sites for three (R35, R42, R57) of three residents reviewed for dialysis in the sample list of 47. Findings include: The facility's Dialysis policy dated as revised January 2022 documents: Dialysis is an artificial kidney treatment that eliminates wastes, removes excess fluid, filters electrolytes in the blood, and controls blood pressure. A subclavian catheter is a flexible tube inserted into a vein under the collarbone, and is covered with a dressing that is only removed for dialysis. Infection can occur at the place where the catheter enters the body, and it is important to keep the dressing clean and dry when the catheter is not in use. A graft is a permanent dialysis access that is surgically inserted and connected to an artery. Blood flows from the artery and through the graft creating a thrill (buzzing sensation) that is felt, and a bruit (roaring sound) that is heard through a stethoscope. During dialysis, needles are placed into the graft. The needles are removed after dialysis and firm pressure is maintained over the puncture site for 15-20 minutes. A bandage should remain in place until the evening of dialysis or until the bleeding has stopped. Complications for fistulas and grafts include bleeding, clotting, and weakened areas along the graft. When clotting is present the bruit and thrill will be absent and surgery is required to remove the clot. The thrill is to be checked every shift and recorded on the treatment sheet. If the thrill is absent, notify the physician as soon as possible. Notify the physician of any signs or symptoms of infection. 1.) On 9/18/22 at 1:28 PM R35 stated R35 started receiving dialysis in August 2022. R35 goes to a dialysis center three times weekly. The nurses do not assess R35's dialysis access site regularly. R35's Minimum Data Set (MDS) dated [DATE] documents R35 is cognitively intact. R35's Care Plan dated 8/18/22 documents R35's dialysis shunt needs monitored, R35 receives dialysis for fluid overload, has dialysis shunt port site to right chest, and receives dialysis three times weekly. Interventions include monitoring the access site for signs of infection and bleeding, obtain assessment and treatment information from center regularly, refer to physician's orders for fluid restrictions and diet orders, encourage compliance with orders, provide education on effects of non-compliance, and and to notify the dialysis center of changes in condition, fluid status, cognition, and Activities of Daily Living needs. R35's August 2022 and September Physician's Orders Summaries (POS) does not include orders for routine monitoring of the dialysis access site, weight monitoring, or frequency of dialysis. R35's August 2022 Treatment Administration Record (TAR) does not document an entry to monitor/assess R35's access site. R35's September 2022 TAR documents to monitor R35's dialysis catheter for infection twice daily, and only documents this was completed on 3 times between 9/1 and 9/20/22. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R35's Nursing Notes document R35 readmitted to the facility on [DATE] with a catheter for dialysis to R35's right chest. R35's medical record does not consistently document ongoing communication/coordination with the dialysis center or the dialysis center's contact information, or that R35's weight is recorded/monitored regularly. The facility's Monthly Weight Grid dated October 2021-September 2022 does not list R35. 2.) On 9/18/22 at 9:45 AM R42 stated R42 recently admitted to the hospital with an infection to R42's dialysis port, and returned to the facility last night. On 9/20/22 at 8:51 AM R42 stated the nurses do not assess R42's dialysis access site. on R42's chest. R42 had a dialysis access catheter and dressing to the left lower neck. R42's MDS dated [DATE] documents R42 is cognitively intact. R42's Care Plan dated 7/19/22 documents R42 receives dialysis for Chronic Kidney Disease three times weekly. Interventions include monitoring the shunt to the right chest for infection and bleeding, and to notify the dialysis center of changes in condition, fluid status, cognition, and Activities of Daily Living needs. The dialysis center and contact information is not recorded in R42's medical record. R42's August and September 2022 POS do not include orders for routine monitoring of the dialysis access site, weight monitoring, or frequency of dialysis. R42's August and September TARs do not consistently document that R42's dialysis access site is monitored/assessed twice daily as scheduled. R42's Infectious Disease Physician's Report dated 9/16/22 documents R42 admitted to the hospital on 9/8/22 and R42 has sepsis secondary to MRSA (Methicillin Resistant Staphylococcus Aureus (multidrug resistant organism) infection of the hemodialysis line. R42's medical record does not document routine communication/coordination with the dialysis center, the dialysis center and contact information, or that R42's weight is obtained/monitored regularly. The facility's Monthly Weight Grid dated October 2021-September 2022 does not list R42. On 9/20/22 at 12:53 PM V10 Dietary Manager stated residents who receive dialysis should have weights recorded at least on dialysis days. V10 confirmed R35's and R42's weights are not recorded on the facility's weight report. On 9/20/22 at 2:14 PM V49 Licensed Practical Nurse (LPN) stated: V49 assesses the dialysis access sites only on the days that the residents go to dialysis, and this is not documented anywhere. There are no communication forms sent with the residents to dialysis or returned from dialysis. We don't know what goes on at dialysis. On 9/20/22 at 3:23 PM V49 and V20 Registered Nurse (RN) confirmed there is no contact information for the dialysis center in R35's and R42's medical records. The phone number for the dialysis center, provided by the facility, was not for the center where R35 and R42 receive dialysis. On 9/20/22 at 3:52 PM V1 Administrator stated V1 thought the facility had an active contract with (dialysis center), but neither the facility nor (dialysis center) have been able to locate a contract. R35, R42, and R57 are the only residents who receive dialysis, and they all use the same dialysis center company. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/20/22 at 4:53 PM V2 Director of Nursing stated: The certified nursing assistants are responsible for obtaining weights. V2 thinks that weights were previously recorded on paper, given to V3 Assistant Director of Nursing, and the weights were never recorded in the charts. The nurses are suppose to fill out a communication form that is sent to dialysis and then dialysis is suppose to complete the form and send back with the resident. You won't find the forms in the chart, because the nurses haven't been using them. Dialysis hasn't been sending documentation consistently. Nurses should be assessing the access sites every shift and should be documented on the TAR. 38780 3.) R57's Medical Record (current) documents diagnoses including Chronic Kidney Disease Stage 5, Hypoxia, and Fluid Overload. R57's Care Plan dated (undated) documents the following: Diabetes-(start date 5/7/22) Resident will maintain accu-check and fasting blood sugar of 60-300 unless otherwise ordered by MD. Insulin Dependent: Administer insulin as ordered. Rotate insulin injection sites. Monitor blood glucose levels thru capillary checks per MD order-See POS for monitoring frequency, rotate draw site. Notify MD if beyond ordered parameters below 60 and/or above 500. Monitor and record daily meal intakes. Resident with dialysis shunt needs monitored (start 7/17/22). Dialysis for Chronic Kidney Disease. Dialysis Schedule every Monday, Wednesday, and Friday. Shunt will remain patent for next 90 days. Monitor fistula for signs of infection redness, swelling, drainage, pain. Monitor site for bleeding; if bleeding occurs apply pressure x 10 minutes, if bleeding persists, notify MD and seek discharge to acute care. Keep site covered, maintain privacy and dignity as able. Monitor bruit and thrill daily, notify MD of changes to auditory assessment of site of left forearm. There is no documentation in R57's medical record of monitoring R57's blood glucose, weight, or fistula site. There is no documentation in R57's medical record of communication between the facility and R57's dialysis center. On 9/18/22 at 10:04am, R57 stated staff have not been checking R57's blood glucose. R57 stated blood glucose is supposed to be checked three times a day with meals. On 9/20/22 at 10:10am, R57 stated the facility does not monitor R57's fistula or weight. R57 stated fistula and weight is monitored at dialysis. R57's September Treatment Administration Record (TAR) was noted in R57's medical record with no treatment order to check for bruit and thrill of R57's left forearm fistula site. The facility failed to provide this document as requested. (continued on next page)

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	145389	A. Building B. Wing	09/21/2022

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/20/22 at 12:05pm, V2 DON stated nurses are supposed to check the site every shift. V2 confirmed there is no order to monitor R57's blood glucose or fistula site. V2 stated this [missing previous orders] happens when a resident goes out to the hospital, comes back and the order isn't carried over.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38780 Based on observation, interview, and record review, the facility failed to ensure the facility was sufficiently staffed to meet the needs of the residents. This failure affects seven residents (R182, R30, R57, R35, R31, R34, R15) and has the potential to affect all 77 residents residing in the facility. Findings include: The facility's Facility assessment dated ,d+[DATE] documents the following: The Facility will be staffed according to residents needs and required staffing guidelines and considerations of continuity of care. On 9/21/21, there were two Certified Nursing Assistants (CNA) and two Nurses observed working on third shift. On 9/18/22 at 8:48am, R30 stated R30 has frequent pain and when R30 requests pain medication during the night it sometimes can take an hour before R30 receives the medication. On 9/18/22 at 10:04am, R57 stated R57 has not been receiving insulin as ordered and staff are not performing accu-checks. On 9/18/22 at 10:17am, R35 stated sometimes there is only one nurse at night 6p-6a. R35 stated, we don't get our medications on time. They don't have enough nurses and CNA's. They need to stop admitting more residents until they have more staff. On 9/18/22 at 10:27am, R31 (R72's spouse/room mate) stated R72 does not get changed as often as R72 should. R31 stated R72 sometimes goes four hours or longer before R72 is changed. R31 stated this happens more on the weekends. R31 stated R72 fell a few days ago while trying to get out of bed to go to the bathroom. R31 stated the facility needs more staff. On 9/18/22 at 10:27am, R34 stated did not receive R34's insulin about a week ago and my blood sugar was around 150. The nurse said it [blood sugar] was too low. Last Friday (9/16/22) there was only one nurse here on nights and it took about an hour and fifteen minutes before I got my meds. On 9/19/22 at 10:00am, R30 stated R30 feels sorry for the staff that are working a lot and they are short staffed so often. R30 stated staff frequently don't show up to work. On 9/19/22 at 10:08am, R15 stated staff will come in to resident rooms, turn off call lights and not return for sometimes over an hour. On 9/20/22 4:53pm, V2 Director of Nursing (DON) stated V2 worked Friday night (9/16/22) from about 10p-6a. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/21/22 at 5:03am V51 Licensed Practical Nurse (LPN) stated V51 worked night shift on 9/16/22. V51 was not aware that R182's tracheostomy had ever been dislodged. R182's humidifier bottle was leaking onto the floor that night and the facility did not have any supplies to change the humidifier. V51 stated trach (tracheostomy) care is not provided during the night unless R182 requests to be suctioned. V51 stated R182 refuses to be suctioned unless R182 requests it. V51 stated V51 has not received any training on trach care through the facility or through the agency that V51 is employed with. V51 stated the nurses answer the phone during the night but sometimes we are in rooms giving medications or completing assessments. V51 stated V46 (R182's Family Member) called that evening and said that R182 had R182's call light on and no one was answering it. V51 stated V2 had just left R182's room prior to V46 calling. V51 stated V46 told V51 that V46 had tried to call earlier but no one answered the telephone. V51 stated V46 asked to speak with V2 and V2 was given the telephone. V51 stated V2 was the only other nurse that worked night shift on 9/16/22 and V2 did not come in until 11:00 PM. V51 stated V51 worked as the only nurse from approximately 6:30 PM until V2 arrived. V51 stated V51 had only passed bedtime medications to C hall and part of B hall prior to V2's arrival. V51 stated there were a lot of residents that hadn't gotten their medications and medications that were given late. V51 stated many of residents were upset that they received their medications late. On 9/21/22 at 5:10am, V52 Registered Nurse (RN) stated V52 has worked twice as the only nurse in the facility on night shift. V52 stated usually the day nurse stays until midnight and a day nurse comes in at 4:30/5:00am. V52 stated, I have been by myself once for about 4.5 hours. It is a lot of residents to take care of and cover 4 halls by myself. V52 stated tracheostomy care is provided for R182 when R182 requests it. V52 stated R182 tells staff what R182 needs and when R182 wants to be suctioned. V52 stated was not aware that R182's trach has ever been dislodged. V52 stated has not received trach care training by the facility and was unsure if V52 had received training through the agency. On 9/21/22 at 10:02am, R182 stated R182's oxygen humidifier tubing that is bled into R182's tracheostomy tubing had popped off during the night. R182 stated R182 put my the call light on and it took staff over 30 minutes to get to R182. R182 explained R182 was banging R182's cup on the bedside table to try and get staff's attention. R182 further explained, I'm new to having a tracheostomy and was very concerned. I was scared that I wasn't going to be able to breath and started to panic. R182 stated since staff were not answering R182's call light, R182 called V46 and requested for V46 to call the facility to summons help. On 9/21/22 at 11:02 am, V46 stated on 9/16/22 around 12:30 am - 1:00 am, one of R182's tubes from the tracheostomy to the Oxygen had fallen out and R182 used the call light for help, but nobody was coming. V46 stated R182 had video called V46 asking V46 to call the facility and ask for help. V46 stated, he [R182] was starting to panic. I called the facility and nobody answered. I then called [R182] back and he [R182] said nobody had came in [to R182's room]. We [V46 and R182] went back and forth like that for 20 minutes and still no answer. I was calling [R182] back to tell [R182] just to call 911 because [R182] was so scared when I got a text from [R182] saying staff finally came in. V46 stated V46 then called the facility again and spoke to the unidentified nurse and the nurse explained to V46 that V2 and the CNA's were down in another resident room providing cares and that the other nurse was in another room therefore nobody heard the call light or R182 banging on the table. The facility Nursing Daily Assignments Sheet documents nurses work 12 hours shifts 6a-6p and 6p-6a. Further documents CNA's work eight hour shifts 6a-2p, 2p-10p, and 10p-6a. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility The Nursing Daily Assignments Sheet for 9/16/22 documents two nurses working 6a-6p and two nurses (V2 and V51) working 6p-6a. The Nursing Daily Assignment sheet for 9/16/22 documents four CNA's working 6a-2p, four CNA's working 2p-10p, and four CNA's working 10p-2a. The facility's Resident Council Meeting Minutes dated 6/15/22 documents the following: Call lights and length of time it takes to get a response was also voiced as a complaint. Resident Council Meeting Minutes dated 9/15/22 documents the following: Call lights are not being answered in a timely manner. Having to wait to long. The Resident Census and Conditions of Residents report dated 9/19/22 documents 77 residents reside in the facility.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 38780 Based on observation, interview, and record review, the facility failed to post the required daily nurse staffing data on a daily basis and failed to maintain these records for 18 months. This failure affects all 77 residents residing in the facility. Findings include: On 9/18/22, 9/19/22, 9/20/22, and 9/21/22 a daily staffing write on board was observed to be on V1 Administrator's office door and by noon, the facility's posting of daily nurse staffing was not posted in the facility and this board remained blank. On 9/21/22 at 11:09am, V1 Administrator stated V1 works with V5 Social Services Director to post daily staffing. V1 stated, it's not posted. All we have right now is our staffing sheets. They [daily nurse staffing] haven't been posted this week. The facility was unable to provide the 18 months of required maintained daily nurse staffing documentation. The Resident Census and Conditions of Residents report dated 9/19/22 documents 77 residents reside in the facility.

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F 0740 Level of Harm - 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** 42702 Based on observation, interview and record review the facility failed to provide behavioral health services and interventions to meet the needs of one (R14) of nineteen initial residents sampled in a total sample list of 47. This failure resulted in ongoing behaviors which resulted in R14 harming R14's self. Findings include: The facility assessment reviewed date 5/22 documents, Common Diagnosis, Physical or Medical Conditions Accepted (to the facility) but not limited to: Psychiatric/Mood Disorders: Psychosis (Hallucination, Delusions, et.) Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Intervention. Resident Support/Care Needs: Mental health and behavior: Manage the medical conditions and medication-related issue casing psychiatric symptoms and behavior, identify and implement intervention to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment care of individuals with depression, trauma/Post Traumatic Stress Disorder, other psychiatric diagnoses, intellectual or developmental disabilities. Include dementia management training and resident abuse prevention training. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. On 2/21/22 R14 was admitted to the facility with the following diagnoses including: Closed Fracture of the Right Hip, Intellectual disability, Anxiety, Cancer of the Prostate, Psychosis with Behaviors and Depression. R14's Minimum Data Set, dated dated dated [DATE] documents R14 as severely cognitively impaired. On 9/21/22 at 10:30AM, R14 laid in bed. V34 Unit Aid was sitting outside of R14's room in eye view of R14. R14 appeared tired and disheveled. V34 Unit Aid said that R14 had to be watched all of the time because of his behaviors. R14's progress notes document the following: 2/23/22 Requires assist with all activities of daily living. Will yell out for whatever he wants even when he has the item. 2/28/22 Up in chair and very agitated today. Was one to one and cursing, throwing things and spitting. Yells loudly and strips off clothing. 3/10/22 Resident agitated, wanting to leave facility and slapped (unknown) peer. 3/16/22 Resident punching and screaming at staff. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	3/14/22 Attempts to stand and transfer self despite unsteadiness. Takes roommates walker but does not use properly. Requires assist with activities of daily living and can be resistive. Takes medications and can be feisty at times with cares. Up walking without assistance. Resists care and screaming that he wants to go home. Resident hitting staff, pulled shade off of window again. Screaming about going home. Throwing pillow and blankets on the floor. 4/6/22 Resident very agitated throughout the day. Up and walking around without wheelchair. Resident throwing items from nursing cart. Asking for staff that are not working. 4/7/22 Resident showed aggressive behavior, slapping staff and spitting. 4/21/22 Attempts to hit staff and self at times. 5/4/22 R14 was in another resident room (in the last room on the A wing) and when staff attempted to redirect, became violent, swinging and hitting staff, looking for a woman. R14's 5/28/22 incident report documents that at approximately 5:30PM, R14 became enraged and punched a glass picture frame in the hallway of the facility resulting in glass in the right hand with a possible fracture. R14 was sent to the local hospital for evaluation and treatment. R14 was then sent to another local hospital and was returned to the facility at 6:00AM on 5/29/22 with orders to see orthopedics and to have the foreign body (glass) removed. R14's 6/6/22 progress notes document, Resident agitated, spitting, combative, throwing objects. Having (unknown) peer to peer altercations. R14's 8/25/22 incident report documents R14 peer to peer altercation. On 9/21/22 at 1:20PM, V4 Memory Care Unit Coordinator stated, I have been doing individual training with staff on dementia/behavioral care. Most of the staff that I've trained no longer work here. Maybe half have the training. On 9/21/22 at 12:00PM V1 Administrator stated, I know that R14 has behaviors, can be agitated and aggressive. The staff try to redirect him and it doesn't always work. He is on one to one observation until we can get him discharged . We haven't had psychiatric services since he has been here (February 2022). In the spring of 2019 they just stopped coming and it hasn't restarted yet. We have a new company starting soon, but we have to get the consents signed before they will come. When they come (R14) will be first on the list to see them. I don't know if he was screened before he was admitted or not. We are just pushed so hard to take any admission that we are accepting residents with more and more behavioral issues because our corporation wants us to. On 9/21/22 at 12:55PM, V2 Director of Nursing stated, The staff lack the training to manage the behavioral needs of the residents. That is one reason we are excited to have the new behavioral health company starting. They are going to provide staff education and training as well as psychiatry for the residents.

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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** 32853 Based on interview and record review the facility failed to completed Psychotropic Medication Assessments, obtain Psychotropic Medication consents, develop Care Plan Interventions for Psychotropic Medication use and develop non-pharmacological interventions for four of four residents (R40, R53, R14, R228) reviewed for Psychotropic Medication use in the sample list of 47. Findings include: The facility's Psychotropic Medication policy with a revised date of 6/17/22 documents, It is the policy of this facility that residents shall not be given unnecessary drugs. Unnecessary drug is any drug used: 1. In an excessive dose, including in duplicative therapy 2. For excessive duration 3. Without adequate monitoring 4. Without adequate indications for its use. Definition of a Psychotropic Medication: Medication that is used for or listed as used for antipsychotic, antidepressant, antimonic, antianxiety behavior modification, or behavior management purposes. Procedure: 2. Psychotropic medication shall not be prescribed prior to attempted non-pharmalogical interventions to decrease behavior. 3. Initiate a Pre-Psychotropic Medication Evaluation prior to administration of a newly prescribed psychotropic medication. 4. Initiate a Psychotropic Medication Quarterly Evaluation within 14 days of admission for those residents currently receiving psychotropic medication. 5. Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative. 8. The Behavioral Tracking sheet of the facility will be implemented to ensure behaviors are being monitored. 9. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue the drugs. Any resident receiving psychotropic medication will be reviewed at a minimum of every quarter by the interdisciplinary team. 17. Any resident receiving psychotropic medication will have the Psychotropic Medication evaluation done at a minimum of every quarter. 18. Any resident receiving any psychotropic medication will have certain aspects of their use and potential side effects addressed in the residents care plan at least quarterly. The care plan will identify target behaviors causing the use of psychotropic medication. The care plan will address the problem, approaches and goals to address these behaviors. 19. Quarterly documentation will be done on a progress note of any resident that currently receives psychotropic medications. 1.) R40's Physician Order Sheet (POS) dated 9/1/22 through 9/30/22 documents diagnoses including Dementia with Behavioral Disturbances, Depression, Insomnia, Behavioral Disturbance with Aggression and Alzheimer's Dementia with Behavioral Disturbance. This POS documents orders for Lexapro (Antidepressant) 10 mg (milligrams) by mouth once a day for Depression and Risperdal (Antipsychotic) 0.5 mg one tablet by mouth twice daily for Dementia with Behavior Disturbance. R40's Minimum Data Set (MDS) dated [DATE] documents R40 was admitted on [DATE] from an acute hospital. This MDS documents R40 has severely impaired cognition, R40 has Delusions and wanders throughout the unit. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R40's medical record contained a blank Pre-Psychoactive Medication Record which contains an Activities of Daily Living (ADL) assessment, Behavior assessment and attempts at lesser alternatives. There is no documentation on this record except R40's name. R40's Care Plan dated 9/6/22 documents R40 requires the use of Psychotropic Medication to manage mood and/or behavior issues. Interventions developed for this area are to administer the anti-depressant as ordered, observe for side effects and obtain informed consent prior to administration of medication. There is no mention of the antipsychotic medication (Risperdal) on R40's Care Plan. R40's medical record contains no assessment or pre assessment or signed consents for the psychotropic medications. 2.) R53's POS dated 9/1/22 through 9/30/22 documents diagnoses including Parkinson's Disease, Depression, Alzheimer's Disease and VP (Ventriculoperitoneal) shunt. This POS documents orders for Lorazepam (antianxiety) 1 mg (milligram) tablet by mouth every six hours (6:00 AM, 12:00 PM, 6:00 PM, 12:00 AM) for anxiety with a start date of 11/26/21, Lorazepam 0.5 mg tablet by mouth twice a day (8:00 AM and 8:00 PM) for anxiety with a start date of 7/18/22, Escitalopram (antidepressant) 5 mg tablet by mouth at bedtime and Lorazepam 0.5 mg tablet by mouth every four hours as needed for Anxiety. R53's MDS dated [DATE] documents R53 was admitted on [DATE] from an acute hospital. This MDS documents R53 has severely impaired cognition and wanders throughout the unit. R53's Care Plan dated 11/26/21 documents R53 requires the use of Psychotropic Medication to manage mood and/or behavior. The interventions developed for this area are to administer the anti-depressant medication as ordered and obtain informed consent prior to administration of medication. R53's medical record does not contain any pre-psychotropic assessments or any psychotropic medication assessments at all. On 9/20/22 at 3:00 PM, V7 Minimum Data Set/Care Plan Coordinator stated that V7 did not have any psychotropic assessments for R53 and R40. 38780 3.) R228's Face Sheet (undated) documents R228 was admitted to the facility on [DATE] with a diagnosis of Dementia with psychosis. R228's Physician Order Sheet (POS) dated 9/13/22 through 9/30/22 documents the following orders: Risperidone (Antipsychotic) 0.25 milligrams (mg) by mouth at three times a day; Risperidone 0.5mg by mouth at bedtime; Mirtazapine (Antidepressant) 30mg by mouth at bedtime and Divalproex Sodium Delayed Release (Anticonvulsant, secondary use for Bipolar Disorder) 125 mg give 250mg by mouth three times a day with meals. There is no documentation in R228's medical record of consents for R228's Risperidone, Mirtazapine, or Divalproex Sodium. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/21/22 at 8:30am, V2 Director of Nursing stated we do not have consents for [R228]. I will attempt to get them today. [R228] has a State Guardian but we aren't even sure who it is. 34201 4.) R14's September 2022 Physician Orders documents Diagnoses of Intellectual Disability, Depression, Anxiety and Agitation with orders for Zoloft {Antidepressant} 25 mg (milligrams) daily, Ativan {Sedative} 0.5 mg BID (twice a day), Depakote {Anticonvulant used to treat certain psychiatric conditions} 125 mg TID (three times a day), and Risperidone {Antipsychotic} 1 mg TID. R14's Psychotropic Medication Constent-Antipyschotic dated 5/11/22 for Depakote documents R14 is receiving Depakote for a Diagnosis of Bipolar with behaviors of yelling outbursts, hitting self, throwing items and lashing out. On 9/18/22 at 8:47 AM, V59 Care Mentor stated R14 outbursts when R14 gets agitated, R14 gets loud and starts talking to R14's self and hitting R14's self in the face. R14's medical record did not contain a consent for Risperidone or Psychotropic Assessments for any of the above listed medications. On 9/19/22 at 12:32 PM, V3 ADON (Assistant Director of Nursing) stated psychotropic consents and assessments are kept in the medical record. V3 reviewed R14's medical record and confirmed there were no assessments for psychotropic medications are in medical record, and stated they don't exist then. Also confirmed no consent for the Risperidone. V3 stated V2 DON (Director of Nursing) is responsible for completing the assessments. On 9/20/22 at 2:26 PM, V2 DON stated the admitting nurse should complete the initial psychotropic assessment and obtain consent for the medication and that V20 is to complete the quarterly ones. V2 state we get to them the best we can. I know assessments are missing, it's like someone went through the charts and removed information and I (V20) haven't been able to find it.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to administer medications in accordance with physician orders and manufacturer's instructions for use for three of six residents (R45, R71, R42) reviewed for medication administration in the sample list of 47. This resulted in 12 medication errors out of 27 opportunities, a 44.44% medication error rate. Findings include: The facility's Medication Administration dated as revised 11/18/17 documents: Medication administration includes verifying the medications with physician's orders. Notify the pharmacy if medications are not available. Administer medications within one hour of the scheduled timeframe. The facility's Pharmacy Medication Orders and Residents Charts dated October 2006 documents: Whenever possible, the licensed nurse receiving the physician order should completely transcribe the order before returning the chart to the rack. Transcription includes transcribing the order to the following: 1. The medication box on the Physician Order Sheet (POS). 2. The medication box on the Medication Administration Record (MAR), PRN (as needed) Administration Record, or Treatment Administration Record, (if applies). F. The transcribed order is then communicated to pharmacy via fax of the telephone order or written order. 1.) On 9/18/22 at 4:19 PM V48 Licensed Practical Nurse (LPN) prepared and administered R45's medications that included Metoprolol 25 mg (milligrams) 1/2 tablet, Acetaminophen 500 mg one tablet, Memantine Hydrochloride 5 mg one tablet, Refresh eye drops 1 drop to each eye, Flonase 50 mcg (micrograms) 1 spray to each nostril. V48 obtained R45's blood glucose level of 150. V48 stated R45 has an order for sliding scale Novolog, but based on R45's blood glucose level insulin Novolog won't be administered. R45's September 2022 Physicians Orders Summary (POS) does not document orders for Metoprolol, Acetaminophen, Memantine, Refresh, Flonase, and Novolog. July and August 2022 POSs were not in R45's medical record. R45's June 2022 POS documents orders for Flonase 50 mcg 1 spray each nostril BID (twice daily), Memantine Hydrochloride 5 mg BID, Metoprolol Tartrate 25 mg 1/2 tab BID all scheduled to be given at 8:00 PM. This POS documents orders for Acetaminophen 500 mg two tablets three times daily, Refresh eye drops one drop each eye four times daily, and Novolog sliding scale three times daily based on blood glucose levels above 150. 2.) On 9/18/22 at 4:43 PM V25 Registered Nurse (RN) handed R71's Albuterol Sulfate 90 mcg inhaler to R71. R71 self administered two consecutive puffs. V25 did not instruct R71 to shake the inhaler prior to use, take a deep breath and hold after each puff, or to wait between administering each puff. R71's September 2022 POS includes orders for Albuterol 1.25 mg/3 ml (milliliters) administer 3 ml via nebulizer three times daily and Albuterol 90 mcg inhaler inhale by mouth as directed as needed. The order does not include the number of puffs to administer or the frequency, and there is no routine scheduled order for the Albuterol inhaler. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The manufacturer's instructions for use for Albuterol 90 mcg inhaler dated April 2019 documents: Shake the inhaler prior to each spray. Breathe out through your mouth to push out as much air from your lungs as you can, breathe in the spray, remove the inhaler, close your mouth and hold your breath for up to 10 seconds. Wait one minute between puffs. 3.) R42's Hospital Discharge Instructions dated 9/17/22 document R42's orders include Glipizide (antidiabetic) 5 mg PO (by mouth) daily before breakfast, Vitamin C 500 mg PO BID, Renvela (lowers phosphorus) 800 mg PO three times daily with meals, and Dificid (antibiotic treatment for Clostridium Difficile, highly contagious multidrug resistant organism) 200 mg by mouth BID for 3 days. R42's September 2022 POS documents an order for Pantoprazole sodium extended release 40 mg by mouth twice daily before meals at 6:00 AM and 4:00 PM. There is no order for Zinc 50 mg. R42's Medication Administration Record (MAR) with an admitted [DATE] documents Dificid, Pantoprazole, Vitamin C are scheduled at 8:00 AM, Glipizide is scheduled before breakfast at 7:00 AM, and does not document to administer Renvela three times daily. On 9/19/22 at 8:20 AM R42 told V49 that R42 had already ate breakfast and asked V49 about the antibiotic that R42 is suppose to be taking. V49 told R42 that R42 was on isolation due to an infection in R42's stools. As V49 LPN prepared R42's medications, V49 stated R42 receives Vitamin C 500 mg. V49 obtained Zinc 50 mg one tablet from an over the counter medication bottle, and not Vitamin C as ordered. V49 administered R42's medications including Zinc 50 mg and Protonix 40 mg. V49 did not administer Dificid, Glipizide, and Renvela as ordered. V49 stated the pharmacy had not yet delivered Dificid, so V49 could not administer the antibiotic. V49 stated V49 did not administer R42's Glipizide since R42 already ate breakfast.

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F 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to administer antibiotics, insulin, cardiac medications, and anticoagulants as ordered resulting in significant medication errors for four (R278, R42, R57, R34) of four residents reviewed for medications in the sample list of 47. Findings include: The facility's Medication Administration dated as revised 11/18/17 documents medication administration includes verifying the medications with the physician's orders, and to notify the pharmacy if medications are not available. The facility's Pharmacy Medication Orders and Residents Charts policy dated October 2006 documents: Whenever possible, the licensed nurse receiving the physician order should completely transcribe the order before returning the chart to the rack. Transcription includes transcribing the order to the following: 1. The medication box on the Physician Order Sheet (POS). 2. The medication box on the Medication Administration Record (MAR), PRN (as needed) Administration Record, or Treatment Administration Record, (if applies). F. The transcribed order is then communicated to pharmacy via fax of the telephone order or written order. 1.) On 9/18/22 at 8:03 AM R278 was lying in bed. R278 had a peripherally inserted central catheter (PICC) line to the right arm and an elastic bandage dressing covering R278's right foot. R278 stated: R278 admitted to the facility from the hospital on 9/16/22. R278 had a right foot amputation and was receiving intravenous antibiotics. R278's nursing notes document R278 admitted to the facility on [DATE] at 6:30 PM. R278's Hospital After Visit Summary for hospital admission 9/6/22 documents: R278 was hospitalized for osteomyelitis (bone infection) and R278's diagnoses include Type 2 Diabetes Mellitus, Coronary Artery Disease, Hypertension, Peripheral Artery Disease, Amputation of right 4th and 5th toes, sepsis, and Vancomycin Resistant Enterococcus foot infection. R278's hospital discharge orders included Metoprolol Succinate 25 milligrams by mouth daily. Taking your medications as prescribed is one of the most vital aspects of reducing your risk for stroke. Do not stop your prescribed medications or begin taking over-the-counter or herbal medications without first speaking with your physician. R278's Physician's Orders Summary (POS) dated 9/16/22 documents R278 admitted to the facility with orders for Unasyn (antibiotic) 3 grams intravenously every 6 hours through 9/19/22, Plavix (antiplatelet) 75 mg (milligrams) PO (by mouth) daily, Norvasc 5 mg PO daily, Prinivil 20 mg PO daily, Heparin (anticoagulant) 5,000 units SQ (subcutaneously) every 12 hours, Levemir (insulin) 14 units SQ twice daily, Humalog SQ per sliding scales four times daily. R278's Medication Administration Record (MAR) dated 9/16/22 does not document Norvasc, Plavix, Prinivil, Heparin, Levemir, and Metoprolol were administered as ordered on 9/17 and 9/18. This MAR does not document R278s' blood glucose levels with sliding scale Humalog was administered as ordered at 8:00 PM on 9/16/22 and 6:00 AM on 9/17/22. This MAR documents Unasyn was not administered at 6:00 AM on 9/17/22 and 9/18/22. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	The facility's emergency medication kit list dated 9/14/22 documents the kit includes six Norvasc 5 mg tablets, six Plavix 75 mg tablets, six Metoprolol Extended Release 25 mg tablets, and six Lisinopril (Prinivil) 5 mg tablets. On 9/18/22 at 2:08 PM V48 Licensed Practical Nurse (LPN) stated medications are delivered by the pharmacy on night shift. V48 stated R278's medications were delivered early this morning on night shift. V48 stated R278's medications are scheduled at 6:00 AM, and V48 did not administer the medications. There were packages of Heparin, Levemir, and Novolog in the medication cart that contained a label with a dispensed date of 9/17/22. On 9/19/22 at 10:08 AM V3 Assistant Director of Nursing stated the nurses have to call the pharmacy to have medications delivered on off hours and weekends. On 9/19/22 at 10:28 AM V3 stated: Nurses are expected to sign the MAR when medications are administered. If medications are not given or refused, the nurse should circle the nurse's initials on the MAR and document they notified the pharmacy and the physician. The nurses should be using the emergency medication kit for medications that are in the supply. R278's Prinivil and Plavix should have been taken from the emergency kit. The facility does not have an emergency insulin kit. R278's medication orders must have missed the cutoff time for R278's medications to be delivered on 9/16/22. 2.) R42's Hospital Discharge Instructions dated 9/17/22 document R42's orders include Renvela (lowers phosphorus) 800 mg PO three times daily with meals, Dificid (antibiotic treatment for Clostridium Difficile, highly contagious multidrug resistant organism) 200 mg by mouth BID for 3 days, and R42 was hospitalized for sepsis secondary to Clostridium Difficile infection and a multidrug resistant infection of R42's dialysis catheter site. R42's Medication Administration Record (MAR) with an admitted [DATE] does not document Dificid was administered as ordered between 9/17/22 and 9/19/22. The Renvela order was not transcribed to R42's MAR. On 9/18/22 02:08 PM V48 LPN stated: R42's Dificid was not available for administration. V48 contacted the pharmacy and was told the medicaiton would be delivered by tomorrow. On 9/19/22 at 8:20 AM R42 asked V49 LPN about R42's antibiotic. V49 told R42 that R42 was on isolation due to an infection in R42's stools. V49 administered R42's morning medications, but did not administer Renvela and Dificid as ordered. V49 stated the pharmacy had not yet delivered Dificid, so V49 could not administer the antibiotic. On 9/19/22 at 10:05 AM V3 Assistant Director of Nursing (ADON) stated: Dificid is about $700, so V3 assumes that is why the medication hasn't been delivered yet. The nurses should have notified V2 DON. The nurses are responsible for transcribing the hospital discharge orders onto the resident's POS and MAR. 38780 3.) R34's Physician Order Sheet (POS) dated 9/1/22 through 9/30/22 documents diagnoses including Diabetes Mellitus, Chronic Kidney Disease Stage 3, and Hypertension. This same POS documents the following orders: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	Accu-check. Once daily at 11am and record site and result. Novolog (fast acting insulin) 100 units/ml (milliliter). Inject 8 units Sub-Q (subcutaneous) twice daily with lunch and dinner. Site of injection. Levemir (long acting insulin) Flextouch 100 units/ml. Inject 18 units Sub-Q every bedtime. Site of injection. R34's Medication Administration Record (MAR) dated 9/1/22 through 9/30/22 does not document Accu-checks being done on 9/2/22; incomplete documentation (missing site, result, or both) for Accu-checks on 9/1/22, 9/3/22 through 9/15/22, 9/17/22 and 9/18/22; Novolog not administered at lunch or dinner 9/2/22; not administered at dinner on 9/12/22, 9/13/22 and 9/15/22 and incomplete documentation (missing injection site) for 9/3/22, 9/4/22, 9/8/22, 9/9/22, 9/10/22, 9/12/22, 9/13/22, 9/14/22, 9/15/22, 9/17/22, and 9/18/22; Levemir Flextouch not administered on 9/14/22 and no injection site documented 9/1/22 through 9/18/22. R34's Care Plan dated 7/10/22 documents the following: Diabetes- Needs monitored for hyper/hypoglycemic reactions. Resident will maintain accu-check and fasting blood sugar of 60-300 unless otherwise ordered by MD. Administer insulin as ordered. Rotate insulin injection sites. Assess for signs of local irritation at injection site. Monitor blood glucose levels thru capillary checks per MD order. See POS for monitoring frequency, rotate draw site. Notify MD if beyond ordered parameters below 60 and/or above 500. On 9/18/22 at 10:27am, R34 stated did not receive R34's insulin about a week ago and my blood sugar was around 150. The nurse said it [blood sugar] was too low. 4.) R57's Medical Record (current) documents diagnoses including Chronic Kidney Disease Stage 5, Hypoxia, and Fluid Overload. R57's MAR dated 9/8/22 documents an order for Lantus (long acting insulin) 100 units/ml. Give 12 units at night. This same record documents R57 was not administered Lantus on 9/9/22 and there is no injection site documented 9/8/22 through 9/18/22. R57's Care Plan dated (undated) documents the following: Diabetes-(start date 5/7/22) Resident will maintain accu-check and fasting blood sugar of 60-300 unless otherwise ordered by MD. Insulin Dependent: Administer insulin as ordered. Rotate insulin injection sites. Monitor blood glucose levels thru capillary checks per MD order-See POS for monitoring frequency, rotate draw site. Notify MD if beyond ordered parameters below 60 and/or above 500. There is no documentation in R57's medical record of monitoring R57's blood glucose. On 9/18/22 at 10:04am, R57 stated staff have not been checking R57's blood glucose. R57 stated blood glucose is supposed to be checked three times a day with meals. On 9/20/22 at 12:05pm, V2 DON confirmed there is no order to monitor R57's blood glucose. V2 stated this [missing previous orders] happens when a resident goes out to the hospital, comes back and the order isn't carried over.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40385 Based on observation, interview, and record review the facility failed to label insulin with opened dates and monitor medication refrigerator temperatures. This failure has the potential to affect all 77 residents residing in the facility. Findings include: The facility's Procurement and Storage of Medications policy dated 11/6/18 documents medications should be labeled with the dispensing pharmacy, resident's name, physician name, name/strength of medication, directions, and dispensed date. This policy documents medications will be labeled with an opened date when the medication seal is opened. The policy does not include a process for monitoring medication refrigerator temperatures. 1.) On 9/19/22 at 11:27 AM V20 Registered Nurse (RN) prepared to administer R34's Novolog 8 units subcutaneously. R34's Novolog vial was not labeled with an opened date. V20 stated V20 would have to get another vial, since this vial was not labeled with an opened date. At 11:44 AM V20 returned with 2 vials of Novolog. One contained a pharmacy label including R34's name and dispensed date of 6/15/22, but did not contain an opened date. The other vial was unopened and was not labeled with a resident's name. V20 administered R34's Novolog from the unopened vial. On 9/19/22 at 11:34 AM the top drawer of the medication cart contained R43's Novolin R vial R63's Humulin N vial, that were not labeled with opened dates. At 11:49 AM R43's Basaglar insulin pen with a dispensed date of 5/10/22 was not labeled with an opened date. V20 confirmed the vials were not labeled with opened dates. R34's September 2022 Physician's Order Summary (POS) documents an order for Novolog 8 units subcutaneously (sub-q) twice daily with lunch and dinner. R43's September 2022 POS documents orders for Novolin R administer sub-q per sliding scale four times daily and Basaglar administer 35 units sub-q daily at 8:00 AM. R63's September 2022 POS documents an order for Humulin N give 14 units sub-q daily at 4:00 PM. 2.) On 9/19/22 at 12:06 PM the medication room was reviewed with V3 Assistant Director of Nursing. The refrigerator contained a controlled medication emergency kit on the top shelf. The paper medication list for the kit was wet with condensation and had ice accumulation. The refrigerator contained insulin pens/vials, Aplisol tuberculin test vials, and Fluzone influenza vaccines. V3 stated there should be a temperature log on the front of the refrigerator, and confirmed there was no log on the fridge. At 12:27 PM V3 stated the influenza vaccine is for the current year, and the influenza vaccines and tuberculin vials could be used for any resident in the facility. On 9/19/22 at 3:56 PM V3 stated V3 was unable to locate temperature logs for the medication refrigerator for August and September. V3 provided a list of medications that were stored in the medication room refrigerator. The undated list documents the refrigerator included R65's three Lantus pens and Insulin Aspart, R4's Novolog pen, R31's five Toujeo insulin pens and Humalog, R34's two Levemir pens, R47's Insulin Lispro, R66's Novolog and Insulin Aspart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R65's September 2022 POS documents Insulin Aspart sub-q per sliding scale three times daily and Lantus 30 units sub-q daily. R4's September 2022 POS documents Novolog sub-q per sliding scale four times daily. R31's September 2022 POS documents Toujeo 40 units sub-q daily and Humalog 10 units sub-q three times daily. R34's September 2022 POS documents Levemir 18 units sub-q daily. R47's September 2022 POS documents Insulin Lispro sub-q per sliding scale four times daily. R66's September 2022 POS documents Insulin Aspart (Novolog) 9 units sub-q three times daily. The facility's Census and Conditions of Residents Report dated 9/19/22 documents 77 residents reside in the facility.

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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. 40385 Based on interview and record review the facility failed to obtain and implement laboratory orders for one (R72) of five residents reviewed for unnecessary medications in the sample list of 47 residents. Findings include: R72's September 2022 Physician's Orders Summary documents: R72's diagnosis include Chronic Kidney Disease, Coronary Artery Disease, Congestive Heart Failure, Type II Diabetes Mellitus, Hypokalemia and Hyperlipidemia. Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), lipid profile, and hemoglobin A1c are ordered to be drawn every 3 months, and uric acid level drawn every 6 months. R72's medications include Eliquis (anticoagulant), Bumetanide (diuretic), and Lantus insulin. On 11/3/21 R72's CBC, CMP, and lipid panel results show R72's Hemoglobin A1C was 7.5 (high), Blood Urea Nitrogen (BUN) was 13 (normal limits), and estimated glomerular filtration rate (EGFR) was 65.95 (normal range). There are no documented CBC/CMP values again until 9/11/22 (10 months later). On 9/11/22 R72's BUN was 32 (high) and EGFR was 48.08 (low). There are no Uric Acid levels or Hemoglobin A1C results after 11/3/21. On 9/21/22 at 11:07 AM V2 Director of Nursing confirmed all of R72's laboratory results in the last year were provided. V2 confirmed R72 has orders to draw laboratory values every 3 months.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to maintain complete medical records for four (R79, R49, R14, R80) of 19 residents reviewed for medical records in the sample list of 47. Findings include: The facility's Thinning Current Resident Records policy revised [DATE] documents: Information contained in the medical records of current residents will be thinned regularly. Once the information is removed, it will be filed chronologically in a thinned folder or envelope. All information will be maintained in such a manner that it is easily accessible upon request from properly authorized persons such as nursing staff or surveyors. Resident medical records are retained for 7 years and begin on the date of the resident's discharge or death. Admission records, admission orders, original assessments, nursing admission assessments and notes, history and physical, inventory list and authorizations must remain in record and not be thinned. Retain 3 months of physician orders, nursing notes, medication and treatment administration records, vitals, weights, therapy notes, and laboratory results in the active medical record. Thin care plans yearly, and retain the current quarter Minimum Data Set (MDS) and the six prior quarterly MDSs. 1.) R79's closed record provided by V2 Director of Nursing, documents R79 admitted to the facility on [DATE]. R79's order dated [DATE] documents R79 was transferred to the hospital. R79's Social Service progress note dated [DATE] documents R79 returned to the facility. R79's medical record does not contain nursing notes, hospital records from [DATE], care plan or code status. The facility did not provide additional records for R79. On [DATE] at 11:45 AM V25 Registered Nurse reviewed R79's medical record and stated This is not complete, there is a lot missing here. V25 stated V25 did not recall if R79 expired in the facility. On [DATE] at 12:00 PM V5 Social Services stated: R79 passed away in the facility. R79 was outside on the patio that day, and complained of being cold. V3 Assistant Director of Nursing was outside with R79. V5 went inside to get R79 a blanket, and upon returning V3 told V5 that R79 was unresponsive. CPR (Cardiopulmonary Resuscitation) was initiated and EMTs (Emergency Medical Technicians) were called. The EMTs continued CPR, administered medications, and called R79's time of death. Corporate came into the facility a few months ago and thinned charts. The documents that were thinned are stored in Building 3, and staff are looking for R79's medical records. On [DATE] at 12:00 PM V18 Business Office Manager stated R79 died on [DATE]. 34201 2.) R14's [DATE] Physician Orders document an order for a pureed diet with honey thick liquids. R14's [DATE] Care Plan does not document a mechanically altered diet. (continued on next page)

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:58 PM, R14 was sitting up on side of bed feeding self a regular diet with thin liquids. On [DATE] at 12:16 PM, V10 Dietary Manager stated R14 is on a regular diet with thin liquids. At this time, V10 provided a Diet Change Slip for R14 dated [DATE] changing R14 to a regular diet with thin liquids. On [DATE] at 12:25 PM, V2 DON (Director of Nursing) stated V2 has been trying to update the diets in the medical record but hasn't been able to get to everyone. V2 confirmed R14's diet order as listed on the Physician Orders is not accurate. 3.) R49's [DATE] Physician Orders document an order for NPO (Nothing by Mouth) and for two cal HN {Enteral Nutrition} to infuse at 35 ml (milliliters) per hour for 24 hours a day. This Physician Order does not document a diagnosis as to why R49 is NPO. On [DATE] at 1:36 PM, V45 ST (Speech Therapist) stated V45 does not know where R49's order came from because R49 hasn't been seen by ST while at the facility, explaining it must have been a recommendation from a swallow evaluation prior to R49's admission. R49's medical record does not contain any Hospital Records or Admitting Orders to show where these orders came from. On [DATE] at 2:00 PM, V2 DON (Director of Nursing) stated R49's medical record was thinned out by the corporate office prior to V2 starting at the facility. V2 doesn't know where R49's thinned record is that would contain hospital records and admitting orders. 32853 4.) On [DATE] at 11:55 AM, V18 Business Office Manager confirmed R80 was admitted to the facility on [DATE] and was discharged on [DATE] and it was an unplanned discharge. V18 stated that V18 had no other information regarding R80 as V18 did not work at the facility at that time. R80's medical record does not contain a recapitulation of R80's stay at the facility, it does not contain any information regarding a bed hold status being provided or R80 being informed of a bed hold policy and there is no documentation to show if R80 or R80's representative was notified of the reason for the transfer out of the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Failures at this level required more than one deficient practice statement. A. Based on record review and interview, the facility failed to have a system in place for infection surveillance that tracks and analyzes infections. This failure has the potential to affect all 77 residents residing at the facility. B. Based on observation, record review and interview, the facility failed to ensure staff wore appropriate Personal Protective Equipment in isolation rooms, that staff who have not received the COVID-19 Vaccination wore appropriate Personal Protective Equipment (PPE), implement contact isolation precautions, post isolation signage, and perform hand hygiene during incontinence care to prevent cross contamination. This failure has the potential to affect all 77 residents residing at the facility. C. Based on observation, interview and record review, the facility failed to screen visitors for COVID-19 prior to entering the facility. This failure has the potential to affect all 77 residents residing at the facility. Findings Include: a) On 9/20/22 at 10:23 am, V3 ADON/IP (Assistant Director of Nursing/Infection Preventionist) provided the Infection Control Book that contained the Infection Control and Antimicrobial Logs from January 2022 - September 2022. These logs are not completed as they do not contain the date the infection was resolved, the infectious organism, or the type of treatment/Antibiotic the infection was treated with. There was also no infection surveillance or data analysis included in the book or provided. On 9/20/22 at 11:04 am, V3 confirmed V3 does not have any infection surveillance or data analysis and that the infection tracking is not complete. V3 stated V3 is only in the facility part time and does the best V3 can. The facility Resident Census and Conditions of Residents Form dated 9/19/22 documents 77 residents reside at the facility. b)1) The facility COVID-19 Vaccine Policy and Procedure dated 6/28/22 documents all HCP (Health Care Personnel) are required to have received at least one dose of an FDA (Food and Drug Administration) - authorized COVID-19 vaccine by January 28, 2022 and the final dose of a primary vaccination series by February 28, 2022. New hires will be subject to the same requirements as current staff and must have received, at a minimum, the first dose of a two dose COVID-19 vaccine or a one dose vaccine by the regulatory deadline or prior to providing any care, treatment, or other services for the facility and/or its residents. On 9/18/22 - 9/20/22 between 8:30 am - 3:30 pm, all staff in the facility were wearing a surgical face mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/20/22 at 10:23 AM, V3 ADON/IP (Assistant Director of Nursing/Infection Preventionist) stated the facility has 20 staff that are not vaccinated and do not have a medical or religious exemption. V3 stated they should not have been allowed to work until vaccinated or exempted explaining V3 thought they {exemptions} were being handled upon hire. V3 stated staff who are not vaccinated should be wearing an N95 (respirator) and goggles and/or faceshield at all times. V3 stated V3 is aware that the unvaccinated staff are not wearing the appropriate/required PPE. At this time, V3 provided a list of the unvaccinated staff who also do not have an exemption, which included the following: V16 CNA (Certified Nursing Assistant), V7 MDS/CP (Minimum Data Set/Care Plan) Coordinator, V28 UA (Unit Aide), V29 CNA, V30 CNA, V31 UA, V32 CNA, V33 Transportation, V34 UA, V35 CNA, V36 CNA, V37 CNA, V38 CNA, V39 UA, V40 UA, V41 UA, V42 CNA, V43 CNA, V44 Housekeeping, V15 CNA On 9/18/22 at 12:37 PM, V16 CNA entered R180's room to provide cares wearing a surgical mask, not an N95 (respirator) mask as required. On 9/19/22 at 10:52 AM, V7 was in V7's office without any type of mask or eye protection. On 9/19/22 at 12:03 PM, V15 CNA entered R180's room to provide cares, and change bedding wearing a surgical mask, not the required N95 mask. V15 also did not have on any eye protection. On 9/20/22 at 11:04 am, V3 stated all residents could come into contact with an unvaccinated staff member due to the facility having so many of them and in different departments. The facility Resident Census and Conditions of Residents Form dated 9/19/22 documents 77 residents reside at the facility. b)2) The facility COVID-19 Control Measures Policy dated 3/25/22 documents for residents in Droplet Precautions, staff are to wear a N95 mask, gloves, gown, and eye protection when entering the room or when working within 6 feet of a resident on droplet precautions. On 9/18/22 at 8:10 AM, R180 was in R180's room with the door cracked open and a sign on the door stating Gray Zone: Contact and Droplet Isolation; Apply PPE (Personal Protective Equipment): gown, gloves, mask/N95, and face shield/goggles. On 9/18/22 at 8:13 AM, V17 Housekeeping was wearing a surgical face mask, donned a gown and gloves and entered R180's room to clean, while R180 was sitting on the bed. V17 did not have an N95 mask on or eye protection. On 9/18/22 at 12:37 PM, V16 CNA (Certified Nursing Assistant) entered R180's room to provide cares wearing a surgical mask, face shield, gown and gloves. On 9/19/22 at 12:03 PM, V15 CNA was entering R180's room to provide cares, and change bedding. V15 changed out V15's surgical mask, donned gloves and gown then entered R180's room without wearing an N95 or eye protection. On 9/20/22 at 10:23 AM, V3 ADON/IP (Assistant Director of Nursing/Infection Preventionist) stated in gray zones/droplet isolation rooms, staff have to wear an N95 mask, goggles and/or faceshield, gown and gloves. You have to protect them {residents} because they aren't vaccinated or fully vaccinated. It's kind of like a reverse isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	40385 b3.) R278's nursing notes document R278 admitted to the facility on [DATE] at 6:30 PM. R278's Hospital After Visit Summary for hospital admission 9/6/22 documents: R278 was hospitalized for osteomyelitis (bone infection) and R278's diagnoses include Amputation of right 4th and 5th toes, sepsis, and Vancomycin Resistant Enterococcus (VRE) (multidrug resistant organism) foot wound infection. The daily note dated 9/12/22 documents R278's right foot wound culture showed heavy growth of VRE faecalis and staphylococcus aureus. There is no documentation in R278's medical record that R278 was placed on contact isolation upon admission. R33's September 2022 Treatment Administration Record documents R33 has a coccyx stage III pressure ulcer. There is no documentation that R33 has an active wound infection. On 9/18/22 at 8:03 AM R278 was lying in bed, and was sharing a room with R33. R278 had a peripherally inserted central catheter (PICC) line to the right arm and an elastic bandage dressing covering R278's right foot. There was no indication that R278 was on contact isolation. R278 stated R278 admitted to the facility from the hospital on 9/16/22. R278 stated R278 had a right foot amputation and was receiving intravenous antibiotics. On 9/19/22 at 7:50 AM R278 and R33 were sharing a room, and there was no indication that R278 was on contact isolation. On 9/19/22 at 3:38 PM V49 Licensed Practical Nurse (LPN) administered R278's right food wound treatment. R278's right toes were amputated, and R278 foot contained sutures in a C shape. There was a large amount of tan drainage on R278's wound dressing. V49 did not apply a gown prior to administering the treatment. V49 disposed of the old dressing into a clear plastic waste bag, and not a biohazard bag. There were no isolation waste and laundry containers in R278's room. R33 was also present and residing in R278's room. On 9/19/22 at 4:12 PM V3 Assistant Director of Nursing (ADON) confirmed when on contact isolation there should be isolation containers for waste and laundry in the resident's room. On 9/19/22 at 4:26 PM V3 confirmed R278's right foot wound culture showed VRE, and confirmed R278 should have been placed on contact isolation. V3 stated R278 should not be sharing a room with another resident, and R278 was going to be moved immediately into a private room and placed on contact isolation. V3 stated V2 DON should have reviewed R278's notes prior to R278's admission and identified that R278 had VRE wound infection. The facility's Contact Precautions policy reviewed 4/11/22 documents: In addition to Standard Precautions, use Contact Precautions, or the equivalent for specified residents known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident (hand or skin to skin contact that occurs when performing resident care activities that require touching the residents dry skin) or indirect contact (touching with environmental surfaces or resident care items in the residents environment). Place the resident in a private room. When a private room is not available, place the resident in a room with a resident(s) who has active infection with the same microorganism, but with no other infection (cohorting). This policy documents to wear a gown in addition to gloves when entering the resident's room and if your clothing will have substantial contact with the resident and environmental surfaces in the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b4.) The facility's Clostridium Difficile (C-Diff) Infection policy reviewed 4/11/22 documents: Use Contact Precautions for residents with known or suspected C-Diff infection. Wear gloves and gowns when entering the residents room and during resident care. R42's Hospital Discharge Instructions dated 9/17/22 document R42's orders include Dificid (antibiotic treatment for C-Diff infection), and R42 was hospitalized for sepsis secondary to Clostridium Difficile infection and a multidrug resistant infection of R42's dialysis catheter site. On 9/18/22 at 8:43 AM there was no signage posted on R42's door to indicate that R42 was on contact isolation. On 9/18/22 at 9:45 AM R42 stated R42 was in the hospital for 3 weeks and just returned to the facility on [DATE]. R42's door contained signage to report to the nurse prior to entering R42's room. There were no isolation containers for waste or laundry in R42's room. On 9/19/22 at 8:20 AM V49 LPN entered R42's room to administer R42's oral medications. There were no isolation containers for waste and laundry in R42's room. V49 did not apply a gown and gloves prior to entering R42's room. V49 told R42 that R42 was on isolation for something in (R42's) stool. V49 placed R42's oxygen cylinder into a bag on the back of R42's wheelchair, applied R42's oxygen nasal cannula into R42's nose, and handed R42's hat to R42. On 9/19/22 at 4:12 PM V3 ADON confirmed when residents are on contact isolation, there should be isolation containers for waste and laundry in the room and signage posted on the door. On 9/19/22 at 4:12 PM V2 DON stated contact precautions for C-Diff requires gloves to be worn, and a gown only if the person comes into contact with it (the C-Diff organism). b5.) On 9/20/22 at 4:11 PM V38 and V50 Certified Nursing Assistants (CNAs) entered R72's room to provide incontinence care. R72's brief was with with a large amount of urine. V50 wiped R72's buttocks, and there was bowel movement present on the washcloth. V50 did not change gloves or perform hand hygiene. Using the same contaminated gloves, V50 applied R72's clean incontinence brief, changed R72's sheets, placed R72's feet on a pillow, handed R72 the bed remote control, and touched R72's oxygen tubing. V50 then left R72's room to obtain another pair of gloves. On 9/20/22 at 4:23 PM V50 stated V50 has not received any training on when to change gloves and perform hand hygiene during incontinence care. V50 confirmed V50 did not change gloves when moving from soiled to clean areas during R72's incontinence care. On 9/20/22 at 4:53 PM V2 DON stated: Staff should be changing gloves and performing hand hygiene during incontinence care when moving from soiled to clean areas. The CNAs say they don't store gloves in resident rooms due to residents getting into them. The facility's Perineal Cleansing policy reviewed December 2017 documents after washing the perineal area, remove gloves and perform hand hygiene prior to applying the new incontinent brief and clothing. c) On 9/18/22 at 7:45 AM, the survey team entered the facility. There was no receptionist at the door. The team was greeted by an unidentified staff member who took the team into the facility conference room and did not instruct the team to complete a health screening. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/19/22 at 8:44 AM, the survey team entered the facility and V18 BOM (Business Office Manager) was sitting at the front desk. V18 did not ask the survey team to complete a Covid 19 control health screening prior to entering the facility. On 9/20/22 at 10:23 AM, V3 ADON/IP (Assistant Director of Nursing/Infection Preventionist) stated visitors are to be greeted at the front door and asked to take temperature and be provided a screening tool before entry. V3 stated it is V18's responsibility to ensure all visitors are screened prior to entering the facility if V18 is present and if not, it's whoever greets the visitor at the door. The facility Resident Census and Conditions of Residents Form dated 9/19/22 documents 77 residents reside at the facility.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 34201 Based on interview and record review, the facility failed to implement their Antibiotic Stewardship Program. This has the potential to affect all 77 residents residing at the facility. Findings Include: The facility Antibiotic Stewardship Program Policy dated 12/12/18 documents this program is to improve the use of Antibiotics in healthcare to protect residents and reduce the threat of antibiotic resistance through a set of commitments and actions designed to optimize the treatment of infections while reducing adverse events associated with antibiotic use. On 9/20/22 at 10:23 AM, V3 ADON/IP (Assistant Director of Nursing/Infection Preventionist) provided the Infection Control Book including the Infection Control and Antimicrobial Log from January - September 2022. This log contained the names of residents with an infection and included the site/type of infection but did not document the microbiology/causative agent or the treatment prescribed. At this time, V3 stated the facility is suppose to have cultures obtained, when able, then the sent to the Physician for proper treatment. V3 stated some physicians are good on waiting to order antibiotics until the culture and sensitivity reports come back and others are not. V3 stated the facility is not able to review the culture and sensitivity reports to ensure the residents are being treated with a susceptible/appropriate antibiotic as they do not get copies of the reports. The facility Resident Census and Conditions of Residents Form dated 9/19/22 documents 77 residents reside at the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Based on interview and record review, the facility failed to assess the vaccination status for four out of five residents (R180, R182, R228 and R279) reviewed for immunizations on the sample list of 47. Findings Include: The facility Immunization of Residents Policy dated 1/23/20 documents at the time of admission and at the start of the recognized mass immunization period, the importance of vaccination against common illnesses such as pneumonia and influenza. Review the resident's Immunization Record, Physician Orders Sheet and Consent form to verify timing of previous vaccinations, allergies and contraindications. R180's undated Face Sheet documents R180 was admitted to the facility on [DATE]. R182's undated Face Sheet documents R182 was admitted to the facility on [DATE]. On 9/20/22 at 12:25 PM, V5 Social Service Director stated V5 meets with residents upon admission to see if they want the influenza and/or pneumoccoal pneumonica vaccinations or not and what their past vaccination status is. R180, R182, R228, and R279's medical records did not contain documentation of their prior vaccination/immunization status. On 9/21/22 at 11:43 AM, V5 stated V5 has not obtained information on R180, R182, R228 or R279's prior vaccination status yet. V5 stated V5 is trying to build a relationship with R180 so R180 will talk with V5 regarding R180's vaccination status. V5 stated V5 hasn't been able to find out who R228 or R279's guardians are yet in order to reach out to them regarding R228 and R279's vaccination status. V5 stated that R182 did not want the pneumococcal or influenza vaccination but does not know about R182's historical vaccination status.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Based on record review and interview, the facility failed to offer the COVID-19 Vaccination to four out of five residents (R180, R182, R228 and R279) reviewed for immunizations on the sample list of 47. Findings Include: The facility COVID-19 Vaccine Policy and Procedure dated 6/28/22 documents COVID-19 vaccinations will be offered to all residents or their representatives if they cannot make health care decisions. R180's undated Face Sheet documents R180 was admitted to the facility on [DATE]. R182's undated Face Sheet documents R182 was admitted to the facility on [DATE]. On 9/20/22 at 12:11 PM, V3 ADON/IP (Assistant Director of Nursing/Infection Preventionist) stated the facility does not have the COVID-19 vaccine on hand at the facility and V3 isn't sure what V2 DON (Director of Nursing) has set up in order for residents to get the COVID-19 vaccination. V3 explained, when V3 was the one handling the vaccinations, V3 was having a hard time getting pharmacy to set up a vaccination clinic. On 9/20/22 at 12:25 PM, V5 Social Service Director stated V5 meets with residents upon admission to see if they want the vaccination or not and what their historical vaccination status is. V5 also stated if a resident refuses the COVID-19 vaccination, and hasn't had one previously, V5 lets the nurse know because the nurse needs to ask them again about it and if the resident still refuses, then the nurse needs to document the refusal in the medical record. R180, R182, R228, and R279's medical records does not contain documentation of their vaccination/immunization status, or that the COVID-19 vaccination was offered. On 9/21/22 at 11:43 AM, V5 stated V5 is trying to build a relationship with R180 so R180 will talk with V5 regarding R180's vaccination status and wishes. Confirmed V5 has not spoken with R180 yet about if R180 would like the COVID-19 vaccination. V5 stated V5 hasn't been able to find out who R228 or R279's guardians are yet in order to reach out to them regarding R228 and R279's vaccination status and to see if they want R228 and R279 to receive the COVID-19 vaccine. V5 stated V5 is unsure if R182 wanted the COVID-19 vaccination. On 9/21/22 at 2:00 pm, V2 DON stated even though V3 is only at the facility part time now, V2 was told that V3 is still the Infection Preventionist and handling all infection control matters, inlcuding COVID-19 vaccinations. On 9/21/22 at 2:45 PM, R182 stated nobody at the facility has offered R182 the COVID-19 vaccination.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 34201 Based on interview and record review, the facility failed to implement their COVID-19 Vaccination Policy and Procedure by failing to ensure all staff are vaccinated against COVID-19. This failure has the potential to affect all 77 residents who reside at the facility. Findings Include: The facility COVID-19 Vaccine Policy and Procedure dated 6/28/22 documents all HCP (Health Care Personnel) are required to have received at least one dose of an FDA (Food and Drug Administration) - authorized COVID-19 vaccine by January 28, 2022 and the final dose of a primary vaccination series by February 28, 2022. New hires will be subject to the same requirements as current staff and must have received, at a minimum, the first dose of a two dose COVID-19 vaccine or a one dose vaccine by the regulatory deadline or prior to providing any care, treatment, or other services for the facility and/or its residents. On 9/20/22 at 10:23 AM, V3 ADON/IP (Assistant Director of Nursing/Infection Preventionist) stated the facility has 30 staff that are not vaccinated against COVID-19. V3 stated the facility does not have COVID-19 vaccinations on hand at the facility but that staff can go to the pharmacy to get the vaccination. V3 stated 20 of the 30 unvaccinated staff are new hires do not have exemptions either. V3 explained the 20 staff without vaccinations or exemptions should not have been allowed to work until they were vaccinated, or had an exemption on file. V3 explained that V3 thought that process was being discussed and taken care of during the new hire process. V3 provided a list of unvaccinated staff without an exemption, which included the following: V16 CNA (Certified Nursing Assistant), V7 MDS/CP (Minimum Data Set/Care Plan) Coordinator, V28 UA (Unit Aide), V29 CNA, V30 CNA, V31 UA, V32 CNA, V33 Transportation, V34 UA, V35 CNA, V36 CNA, V37 CNA, V38 CNA, V39 UA, V40 UA, V41 UA, V42 CNA, V43 CNA, V44 Housekeeping, V15 CNA. On 9/20/22 at 11:04 am, V3 stated all residents could come into contact with an unvaccinated staff member due to the facility having so many of them and in different departments. On 9/21/22 at 2:00 pm, V2 DON (Director of Nursing) stated even though V3 is only at the facility part time, V2 was told that V3 is still the Infection Preventionist and handling all infection control matters, including COVID-19 vaccinations. The facility Resident Census and Conditions of Residents Form dated 9/19/22 documents 77 residents reside at the facility.