STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. Building B. Wing	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Peoria Heights	1629 East Gardner Lane Peoria Heights, IL 61616

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899 Based on interview and record review the facility failed to prevent employee to resident verbal abuse for one resident (R2) of three residents reviewed for abuse. Findings include: Facility Policy/Abuse Prevention and Reporting dated/revised 1/22/19 documents: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes verbal abuse, sexual abuse, physical abuse and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Current Physician Order Sheet indicates R2 was admitted to the facility on [DATE] with diagnoses that include Diabetes Mellitus, Morbid (Severe) Obesity, Major Depressive Disorder, Low Back Pain, Weakness, Left Leg Pain and Diarrhea. Final Abuse Investigation Report (Original Allegation 11/16/21 at 10am) reported alleged verbal abuse. Report indicates V7 and V8 (CNAs/Certified Nursing Assistants) reported verbal abuse of R2 by V10 (CNA.) Report indicates R2 is alert and oriented to self and surroundings. Written interview statement of V7 (CNA) by V1 (Administrator) indicates V7 reported that (on 11/16/21) V10 told R2 that R2 is always sh**ty (soiled) and that R2 was going to stay up all day. Statement indicates V10 also brushed (R2) off when (R2) complained of leg pain during the lift transfer and also called R2 lazy and always complaining. Statement indicates V7 stated it was technically verbal abuse. Written interview statement of V8 (CNA) by V1 (Administrator) indicates that V8 reported that (on 11/16/21) V10 told R2 she was tired of R2 complaining and tired of cleaning R2 up like a three-year-old and that R2 was going to have to stay up until after lunch. Statement indicates that when R2 complained of R2's legs hurting during transfer, V10 stated My legs hurt too. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report indicates that R2 was interviewed on two separate occasions and stated that getting up on (11/16/21) wasn't good but could not recall why. On 12/9/21 both V7 and V8 were interviewed and stated they were assisting V10 with R2 on 11/16/21 - and were eyewitnesses to V10's treatment of R2 at that time. Both V7 and V8 confirmed their written statements were true and correct. V8 further stated that it was her first day working at the facility and she couldn't believe what V10 was saying to R2. V8 stated It was my first day and I had to be a mandated reporter. I do believe (V10) was being verbally abusive to (R2). V8 stated that R2 wasn't really saying anything back to V10 but did tell V10 she complains all the time too. On 12/8/21 at 11:20am R2 stated that she did recall the day the V10 was mean to her. R2 stated that it made her angry and she wanted to get up and hit V10 but was helpless and just had to take it. R2 stated that she didn't want to get anyone in trouble but knows V10 is not supposed to treat her like that. On 12/9/21 at 11:30am V2 (DON/Director of Nursing) stated that she was not part of the decision whether to substantiate abuse or not but R2 is with it and able to understand what's going on. On 12/9/21 at 1:30pm V1 (Administrator) stated that when they interviewed R2, R2 really couldn't recall the event specifics but acknowledged that something did occur with V10 and R2 (on 11/16/21). V1 stated that he did not believe the statements V10 made to R2 were abusive because R2 stated R2 felt safe in the facility when he interviewed R2 and couldn't recall what specifically happened.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899 Based on interview and record review the facility failed to immediately report an allegation of sexual abuse to a supervisor or facility administrator for one resident (R1) of three residents reviewed or abuse. Findings include: Facility Policy/Abuse Prevention and Reporting dated/revised 1/22/19 documents: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. Physician's Order Report indicates R1 was admitted to the facility on [DATE] with diagnoses that include Bipolar Disorder, PTSD (Post Traumatic Stress Disorder), HIV (Human Immunodeficiency Virus) and Hepatitis C. Final Abuse Investigation Report indicates on 11/26/21 at approximately 9:10pm R1 accused V3 (RN/Registered Nurse) of sexual abuse. On 12/7/21 at 12:30pm R1 stated the first person she told (about V3) was V6 (CNA/Certified Nurse Assistant). On 12/7/21 at 2:13pm V6 (CNA) stated that she went outside with R1 to smoke because R1 has to be supervised at all times. V6 stated that when they were outside, R1 said R1 had something to tell her and when they came inside R1 said that V3 (RN) wanted R1 to give him oral sex. V6 stated that she asked R1 if R1 wanted to tell someone and escorted R1 back to R1's room because R1 is not supposed to be out of the room by self. V6 stated that they were short (staffed) that evening, and she had to go help with another resident. V6 stated that she intended to tell what R1 had told her but had to help with another resident. V6 stated that while she was helping with the other resident, R1 snuck out of R1's room and went to the other nurses' station and told V4 (LPN). V6 acknowledged staff are supposed to tell a supervisor or the administrator right away if there is an allegation of abuse. On 12/7/21 at 1:40pm V4 (LPN) stated she was charting at the nurses' station on XXX hall when R1 came walking up and started talking, saying I can't believe he did this to me. V4 stated that she asked R1 what R1 was referring to, and R1 stated that V3 put his penis in R1's mouth after V3 gave R1's medications. V4 stated she called and talked to V3 to tell him what R1 had reported. V4 stated she then notified V1 (Administrator) and V2 (DON). V4 stated she also notified R1's physician and family.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899 Based on interview and record review the facility failed to thoroughly investigate and recognize verbal abuse for one resident (R2) and failed to protect residents from further potential abuse. This failure has the potential to affect all 76 residents in the facility. Findings include: Facility Policy/Abuse Prevention and Reporting dated/revised 1/22/19 documents: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes verbal abuse, sexual abuse, physical abuse and mental abuse. Facility Abuse Prevention Policy and Acknowledgement of Abuse Prevention (signed by V10 Certified Nurse Assistant/CNA) on 6/24/21 documents: Verbal Abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. Mental Abuse includes but is not limited to, humiliation, harassment, threats of punishment or deprivation. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. V10 written acknowledgement of the Abuse Policy included I understand that I will be discharged if I am the perpetrator of the abuse, mistreatment, neglect or misappropriation of property. Current Physician Order Sheet indicates R2 was admitted to the facility on [DATE] with diagnoses that include Diabetes Mellitus, Morbid (Severe) Obesity, Major Depressive Disorder, Low Back Pain, Weakness, Left Leg Pain and Diarrhea. Final Abuse Investigation Report (Original Allegation 11/16/21 at 10am) reported alleged verbal abuse. Report indicates V7 and V8 (CNAs/Certified Nursing Assistants) reported verbal abuse of R2 by V10 (CNA.) Report indicates R2 is alert and oriented to self and surroundings. Written interview statement from V7 (CNA) by V1 (Administrator) indicates V7 reported that (on 11/16/21) V10 told R2 that R2 is always sh**ty(soiled) and that R2 was going to stay up all day. Statement indicates V10 also brushed (R2) off when R2 complained of leg pain during the lift transfer and also called R2 lazy and always complaining. Statement indicates V7 stated it was technically verbal abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Written interview statement from V8 (CNA) by V1 (Administrator) indicates that V8 reported that (on 11/16/21) V10 told R2 she was tired of R2 complaining and tired of cleaning R2 up like a three-year-old and that R2 was going to have to stay up until after lunch. Statement indicates that when R2 complained of R2's legs hurting during transfer, V10 stated My legs hurt too. Report indicates that R2 was interviewed on two separate occasions and stated that getting up on (11/16/21) wasn't good but could not recall why. On 12/9/21 both V7 and V8 were interviewed and stated they were assisting V10 with R2 on 11/16/21 - and were eyewitnesses to V10's treatment of R2 at that time. Both V7 and V8 confirmed their written statements were true and correct. V8 further stated that it was her first day working at the facility and she couldn't believe what V10 was saying to R2. V8 stated It was my first day and I had to be a mandated reporter. I do believe (V10) was being verbally abusive to (R2). V8 stated that R2 wasn't really saying anything back to V10 but did tell V10 she complains all the time too. On 12/8/21 at 11:20am R2 stated that R2 did recall the day the V10 was mean to R2. R2 stated that it made R2 angry and R2 wanted to get up and hit V10 but was helpless and just had to take it. R2 stated that R2 didn't want to get anyone in trouble but knows V10 is not supposed to treat R2 like that. On 12/9/21 at 11:30am V2 (DON/Director of Nursing) stated that she was not part of the decision whether to substantiate abuse or not but R2 is with it and able to understand what's going on. The Final Abuse Investigation Report does not indicate whether abuse was substantiated or unsubstantiated. The report does indicate V10 (CNA) was suspended during the investigation, educated on Customer Service and allowed to return to work. V10 Attendance Time Sheet indicates V10 worked a total of five days in resident care areas between return from suspension on 11/16/21 and suspension on 12/2/21 for an accident during a mechanical lift transfer with another resident. Attendance Sheet also indicates V10 worked all areas of the facility within those five days. On 12/9/21 at 1:30pm V1 (Administrator) stated that he didn't think what V10 said to R2 was abuse because when they interviewed R2, R2 really couldn't recall the incident specifics and said R2 felt safe in the facility. V1 did acknowledged that something did occur with R2 and V10 but did not believe the statements V10 made to R2 were abusive. V1 stated that it is the policy of the facility that if a staff member is found guilty of abuse, they are terminated.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30224 Based on observation, interview, and record review, the facility failed to ensure two staff assisted with a mechanical lift transfer (R5). The facility failed provide supervision to prevent falls (R6), investigate each fall to determine the root cause analysis, and implement appropriate interventions after a fall (R6), for two of three residents (R5, R6) reviewed for falls in the sample of seven. These failures resulted in R5 being dropped out of a mechanical lift sling onto the floor, fracturing R5's left humerus (bone between elbow and shoulder) that caused R5 pain and R6 falling while unsupervised in R6's room that resulted in R6 fracturing R6's right talus (bone in foot that forms part of the ankle joint). Findings include: The Facility's Fall Prevention Program dated 11/21/17, states Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions. The Director of Nursing is responsible for monitoring the Fall Prevention Program. Residents who require assistance will not be left alone after being assisted to bathe, shower, or toilet. This policy is a guideline only. Each resident has his or her own set of circumstances which may require that this policy not be followed. The needs of each resident supersede this policy. The Facility's Transfers-Manual Gait Belt and Mechanical Lifts policy dated 1/19/18, states In order to protect the safety and well-being of the Staff and Residents, and to promote quality care, this facility will use Mechanical lifting devices for the lifting and movement of Residents. The transferring needs of residents will be assessed on an ongoing basis and designated into one of the following categories: Independent, 1-person transfer, 2-person transfer (ONLY when use of mechanical lift is not possible, sit to stand lift with 2 caregivers, and Mechanical lift with 2 care givers. Failure to comply with lifting guidelines may result in disciplinary action as deemed appropriate. 1. On 12/8/21 at 11:30 a.m., R5 was lying in bed with a sling on the left arm. R5 stated I have a broken arm because I was dropped. R5 stated (V10 Certified Nurse Aide/CNA) was transferring R5 from the wheelchair to bed and the next thing I knew I was on the floor. I was sent to the hospital, but I don't think I was admitted . My family and I declined surgery because of my age. I have been in terrible pain in my left arm and shoulder area. The nurses give me pain medications, but it just doesn't last long enough. R5's Minimum Data Set assessment dated [DATE] document R5 has severely impaired cognition. R5's Care Plan dated 11/16/21, documents R5 is total assist of two staff for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R5's Fall Report dated 12/2/21 at 9:00 p.m., documents the following: R5 was being transferred to bed by V10 (Certified Nurse Aide) via full mechanical lift when a strap came loose by R5's left shoulder and R5 fell to the ground landing on R5's left side. V14 (Licensed Practical Nurse) assessed R5 and found R5 had pain and swelling at the left shoulder area. R5's Physician ordered an urgent X-ray which showed a humeral surgical neck fracture. R5's Shoulder X-Ray dated 12/2/21 at 4:18 a.m., states Acute mildly displaced fracture of the left proximal humeral surgical neck. R5's Emergency Department Physician Note dated 12/3/21 at 3:51 a.m., states (R5) complaining of left shoulder, elbow and wrist pain. R5's Final Report to the State Agency dated 12/9/21, documents (in addition to above fall report) (R5's) family refused any surgical intervention and (R5) was returned to the facility. (R5) is to wear a sling to left arm at all times and pain management is in place. Staff re-educated on full mechanical lift procedure and ensuring all straps of (mechanical lift) sling are secure prior to starting transfer. Facility (mechanical) lifts and slings were checked for any mechanical issues and safety (with no concerns identified). On 12/8/21 at 12:55 p.m., V14 (Licensed Practical Nurse) stated I was (R5's) nurse working 6 p.m. to 6 a.m. on 12/2/21 when V10 (Certified Nurse Aide) dropped (R5) out of the (mechanical lift). I was passing medications down the opposite end of the hall from (R5's) room when (V10) came to me and reported that (R5) had shoulder pain. I told her I would be headed to (R5) soon and to tell (R5) I would bring (R5) pain medicine. I asked (R5) what was going on. (R5) told me that (R5's) shoulder hurt and that (R5) had fallen. Then (V10) started telling me that (R5) fell on the floor because the (mechanical lift) sling fell off the loop/clip. I educated (V10) that all (mechanical lift) transfers are to be done with a minimum of two staff assist. V10's statement regarding R5's fall from the mechanical lift on 12/2/21 documents the following: V10 transferred R5 from the wheelchair to bed with a mechanical lift and no other staff assistance. R5's sling loop slipped off the hook and R5 fell to the ground with V10 trying to catch R5, V10 fell on top of R5. V10's statement does not document any further details. On 12/13/21 at 1:43 p.m., V10 stated (via telephone interview) that she could not give any details of R5's fall on 12/2/21 until her union told her it was okay to do so. On 12/9/21 at 11:12 a.m., V2 (Director of Nursing) stated V10 (CNA) did transfer R5 with a mechanical lift by herself when R5 fell from the mechanical lift on 12/2/21, and the facility policy is that all mechanical lift transfers require a minimum of two staff assist. On 12/14/21 at 10:37 a.m., V2 stated My investigation of (R5's fall on 12/2/21) documents that (V10) transferred (R5) by herself. (V10) was terminated (12/13/21). 2. On 12/8/21 at 12:40 p.m., R6 was propelling self in a wheelchair by using R6's feet, from R6's room to the dining room for lunch. R6's right leg/foot had a hard plastic boot in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R6's Minimum Data Set assessment dated [DATE], documents R6 was admitted on [DATE], has moderately impaired cognition; requires extensive assistance with transfers; is unable to ambulate; uses a wheelchair; and R6 has an unsteady balance moving from seated to standing position and surface to surface transfer. R6's Care Plan dated 11/16/21, documents R6 is at high risk for falls related to deconditioning, gait/balance problems, incontinence, and being unaware of her safety needs. R6's Fall Report dated 11/5/21 at 11:55 a.m. documents the following: R6 had an unwitnessed fall in R6's bathroom. R6 stated R6 thought R6 could go to the bathroom by self and ended up on the floor. R6 had no injury. Immediate intervention was to educate R6 to use the call light and wait for help. R6's Fall IDT (Interdisciplinary Team) note dated 11/8/21 at 10:57 a.m., states The root cause of R6's fall (on 11/5/21) was transferring without assistance. New Intervention and care plan updated. (R6) receiving (Physical and Occupational) therapy. R6's Fall Report dated 11/12/21 at 2:15 p.m., documents the following: R6 had an unwitnessed fall in R6's room and was found sitting next to R6's bed. R6 stated R6 dropped R6's phone and leaned over to pick it up and fell forward out of the wheelchair. R6 did not have any injuries. A Reacher was provided to R6 and R6 was educated on its use and to use the call light for assistance. R6's Fall IDT note dated 11/15/21, states The root cause of fall (11/12/21 at 2:15 p.m.): Leaning too far forward in (wheelchair). Intervention and care plan updated: (R6) was given a Reacher to utilize for picking things up off the ground. R6's Fall Report dated 11/13/21 at 6:30 a.m., documents the following: R6 had an unwitnessed fall in R6's bathroom. R6 stated I couldn't wait for help to come, I did it myself. R6 had no injuries. New interventions: Laboratory orders received and encouraged (R6) to stay in supervised area when up in wheelchair. V20's (Certified Nurse Aide) statement on the fall report states I was getting (R6) up and I took (R6) to the bathroom (and) I went to get assistance with (R6's) transfer to the toilet. When I came back (R6) was on the floor in the bathroom face down. (R6) did not call for help. R6's fall IDT note dated 11/15/21, states Root cause of fall (11/13/21 at 6:30 a.m.): (R6) attempting to use bathroom and transfer without staff assistance. Intervention and care plan updated: Staff to offer toilet (every two) hours. On 12/14/21 at 11:57 am., V2 stated I must have missed (V20's) statement (on R6's Fall Report dated 11/13/21) because the intervention we put in place was not appropriate. V2 stated a more appropriate intervention would have been not to leave R6 alone in the bathroom. V2 stated R6 must be supervised because she is very confused and forgets that she is not independent. R6's Physician Note dated 11/17/21 at 3:26 p.m., documents R6 was seen by the physician who noted R6 had several falls attempting to self-transfer since admission. R6's physician stated R6's lab work was negative with a plan to Monitor (R6). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R6's Fall Report dated 11/19/21 at 7:00 p.m., documents the following: R6 had an unwitnessed fall in R6's room. R6 was heard yelling from the room and R6 was found lying on floor, abdomen side down, near the dresser and wheelchair. R6 stated R6 was trying to reach for something, but R6's vision was poor, and misjudged the distance. R6 stated R6's ribs hurt and R6 did hit R6's head and it was also sore. R6 was sent to the hospital for evaluation. R6's Hospital X-Ray report dated 11/19/21 at 10:03 p.m., states Impression: Suspect acute Talar fracture. R6's Hospital Physician Note dated 11/19/21 at 11:21 p.m., states Clinical Impression: 1. Other fracture of right talus 2. Head contusion 3. Fall. R6's Nurses Note dated 11/20/21 at 8:32 a.m., states (R6) returned to the facility via (ambulance) stretcher. (R6) sent to the hospital on 11/19/29 related to a recent fall, rib pain, ankle pain. (R6's) diagnosis is fracture of right talus and head contusion. (R6) complaining of pain at this time, rating pain (at 7 out of 10 on the pain scale). R6's Fall Report dated 11/21/21 at 3:22 a.m., documents the following: R6 had an unwitnessed fall and was found lying on the floor in R6's room next to the bed. R6 reported R6 was sleeping in R6's bed when R6 suddenly rolled out of bed and landed on the floor. R6 had no injuries. On 12/14/21 at 10:37 a.m., V2 stated there is not a Fall IDT note or documented investigation with root cause analysis and updated interventions for R6's falls on 11/19/21 and 11/21/21 falls. V2 stated we missed them for some reason. R6's Fall Report dated 11/26/21 at 5:35 p.m., documents the following: R6 had an unwitnessed fall in R6's room. R6 was calling for help and was found lying on the left side, head near bed, legs toward door, oxygen off but right next to face. R6 had no injury. Immediate Intervention that (R6) will be the last one up and first one to bed around mealtime. R6's Fall IDT note dated 11/29/21, states The root cause of fall (11/26/21 at 5:35 p.m.): non-compliance with staying in dining room and went to room attempting to pick up something off the floor while in (wheelchair). Intervention and care plan updated: will be taken to dining room for meals close to mealtime as resident agrees to. R6's Fall Report dated 11/27/21 at 11:25 a.m., documents the following: R6 had a witnessed fall in her room. R6 was observed to be sitting on buttocks with back against the bed and legs extended forward. R6 stated I didn't fall. I just slid off the bed. There was no witness statement with this report. R6's Fall IDT note dated 11/29/21 at 10:12 a.m., states Root cause of fall (11/27/21 at 11:25 a.m.): (R6) had sock with no shoes on. Intervention and care plan updated: (R6) to have proper footwear on at all times when not lying in the bed. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/8/21 at 12:30 p.m., V18 (Licensed Practical Nurse) stated (R6) is usually not a problem with falls when R6 is in bed, it's usually when R6's in the wheelchair and reaching for things on the floor. We have given R6 a grabber to use due to R6's poor balance. We try to keep R6 in sight at all times unless R6's in bed but R6's quick and sometimes gets past us. V18 stated R6 did recently have a fall that resulted in a fracture (right Talar) and now is wearing a boot on R6's right foot. On 12/8/21 at 12:15 p.m., V17 (Certified Nurse Aide) states R6 is wearing a boot on the right foot due to a fracture received from falling. V17 stated R6 likes to pick things up off the floor. V17 states R6 is confused and doesn't remember that R6 has poor balance. V17 stated staff gave R6 a Reacher/grabber to use but R6 still will lean over and try to pick something up off the floor. On 12/9/21 at 11:13 a.m., V2 (Director of Nursing) stated R6 Likes to pick stuff up off the floor. We've given R6 a Reacher. R6 has poor balance. I've implemented a lot of interventions, but R6's still had quite a few falls. R6 is non-compliant and confused. R6 forgets that R6 needs help. R6 did have a fall that resulted in a Talar fracture. R6 had taken self back to R6's room and fell . I don't know what else I can do to keep R6 from falling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. Building B. Wing	12/15/2021

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 30224 Based on observation, interview, and record review the facility failed to ensure a shower room was clean and sanitary for resident use. This has the potential to affect all 78 residents residing in the facility. Findings include: The Facility's Housekeeping Cleaning Schedule policy (undated), states To establish a schedule which ensures the building and equipment is maintained in a clean and sanitary manner. All items may be cleaned more frequently, if necessary. 1. Daily: a. Toilet, lavatory, and central bathing areas (including floor mats) b. Shower walls; 4. Quarterly: a. Cubicle curtains in bathing areas. On 12/9/21 at 9:20 a.m., the XXX hall shower room had a large shower area (approximately 10 foot by 3 foot) to the right of the entrance that had three shower heads. The shower floor and walls were ceramic tile and were soiled with a dark brown substance from the base of the floor up the wall approximately 18 inches. The grout between the tiles was soiled. The shower floor was soiled with randomly scattered brown and white substances. The drains were covered in white substance. The drain located just outside of the perimeter of the shower floor was soiled with a substance that had the appearance of wet dirt and sand. There was a privacy curtain for the shower area that was soiled up the curtain at least three feet from the bottom. It was substantially darker than the rest of the curtain and had splattered brown substances on it. The toilet was missing the bolt (closest to the shower area) that held the toilet to the floor. The toilet was soiled inside the bowl with a rust color and the toilet seat and around the base of the toilet was wet. On 12/9/21 at 9:25 a.m., V1 (Administrator) stated he had no idea the XXX hall shower room was this filthy. V1 stated no one had reported this to him and he had not been in there to observe the area himself. V1 stated the shower room should be cleaned at least daily and the shower curtain should be kept clean also. V1 stated it was obvious that no one was cleaning in the XXX hall shower room. V1 stated I would not feel comfortable taking a shower in here. On 12/9/21 at 9:32 a.m., V12 (Housekeeper) stated I don't clean the shower area or toilet in this shower room (XXX hall) because I've broken my leg in the past. The maintenance department is responsible to clean that shower and toilet area. I don't know why it's not getting done. I wouldn't take a shower in here. It's filthy and I wouldn't want that privacy curtain to touch me. It needs washed. V1 stated a lot of the residents that live in the facility are independent and can shower themselves when and where they chose to. On 12/9/21 at 11:42 a.m., V1 stated housekeeping is responsible to clean the shower rooms at least daily. On 12/9/21 at 11:12 a.m., V2 (Director of Nursing) stated the shower rooms should be cleaned daily by the housekeepers but the Certified Nurse Aides can also make sure to pick up after each shower they assist with. V2 stated it was not acceptable for the shower room to be that dirty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. Building B. Wing	12/15/2021

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/8/21 at 2:30 p.m., R8 stated the XXX hall shower room is filthy. R8 stated R8 showers independently and uses the YYY hall shower room (a different side of the facility), which is cleaner than XXX hall. R8 stated that R8 would never have R8's shower or bathroom at home be so dirty and these older residents who have to go in there, shouldn't have to go in such an unclean shower. It's not right. They just leave it like that. R8 stated the toilet in the XXX hall shower room is also dirty and unsafe. On 12/13/21 at 9:08 a.m., V1 stated typically residents residing on the XXX hall will use the XXX hall shower room. V1 stated however, residents are free to utilize the shower room of their preference. A Daily Census Report dated 12/7/21, provided by V1 (Administrator), documents there are 78 residents residing in the facility.