STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145308	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River View Rehab Center	50 North Jane Elgin, IL 60123

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to ensure a dependent residents fingernails were trimmed and hands cleaned for 1 of 1 residents (R20) reviewed for activities of daily living in the sample of 35. The findings include: R20's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, hypertension, hyperlipidemia, vascular dementia without behavioral disturbance, dysphagia, cerebral atherosclerosis, and paranoid schizophrenia. R20's facility assessment showed he has moderate cognitive impairment and requires substantial to maximum assistance with all cares. On 10/29/24 at 10:27 AM, R20 was lying in bed. R20's left hand was contracted. R20's fingernails on his left hand were very long and discolored from residue under his nails and his nails were pushing into the palm of his hand. On 10/29/24 at 10:34 AM, V5 (Wound Care Nurse) assessed R20's left hand. V5 said, This is not good, these finger nails are long, the podiatrist is scheduled to come. They cut the residents nails. V5 was using wound care spray and spraying R20's palm and wiping away debris that was in R20's hand. V5 said it appeared to be dried food that was in R20's hand. On 10/31/24 at 9:02 AM, V15 CNA (Certified Nursing Assistant) said, These are too long. CNAs can trim the resident's finger nails. They should trim them anytime they get long. V15 said R20's fingernails need cleaned and trimmed because they collect dirt and he could scratch himself. On 10/31/24 at 12:54 PM, V2 DON (Director of Nursing) said she expects resident fingernails should be checked, cleaned, and trimmed with showers. The facility's policy and procedure dated 4/14 showed, Care of Nails . Purpose: To provide cleanliness. To prevent infection. To promote safety . Procedure: 1. Observe condition of resident nails during each time of bathing . Note cleanliness, length, uneven edges, hypertrophied nails .

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to ensure a fluid restriction was in place for 1 of 2 residents (R30) reviewed for fluid restrictions in the sample of 35. The findings include: R30's face sheet showed he was admitted to the facility 7/2/2018 with diagnoses to include spina bifida, Type 2 Diabetes, iron deficiency anemia, hyperlipidemia, hypokalemia, neuromuscular dysfunction of bladder, Major Depressive Disorder, need for assistance with personal care, and hypo-osmolality and hyponatremia. R30's facility's assessment dated [DATE] showed he has no cognitive impairment and requires supervision through maximal assistance for cares. R30's 10/17/24 acute care hospital documents showed, . After Visit Summary . Admission Diagnoses: . Hyponatremia; Cystitis . Fluid Restriction . 1800 ml . R30's physician order sheet showed an order dated 10/17/24 for Fluid Restriction: 1800 ml/day every shift for hyponatremia . On 10/29/24 at 9:43 AM, R30 said, Right now I got a limit on liquids but it is too hard to for them to watch and I don't think they are paying attention to it either. It started due to a salt level being too high I think . On 10/31/24 at 10:59 AM, V7 CNA (Certified Nursing Assistant) said R30 has no fluid restrictions. R30 said, If it's not on their meal card it would be in the system as their diet order. It should show on our Kardex (resident care information card) in the computer and I see no fluid restriction at all. R30's dietary card showed no fluid restriction. On 10/31/24 at 11:04 AM, V14 RN (Registered Nurse) said R30 is on a fluid restriction and the dietary department was informed. On 10/31/24 at 11:13 AM, V17 (Dietary Manager) said R30 had a fluid restriction but after R30 went to the hospital they removed it. V17 said if there was a fluid restriction, it would show on the resident's dietary card and the Dietitian gives the break down of the restriction. On 10/31/24 at 12:43 PM, V2 said the breakdown of R30's fluid restriction was that he went to the hospital and when he came back the order was renewed and the dietary supervisor said this time he did not get the copy of the fluid restriction. V2 said the dietary department would usually receives a copy of the order from the nurse and they would update the resident's dietary card. The risks of not following a fluid restriction for R30 would be hyponatremia because that is the reason he was sent out to the emergency department before. The order should have been relayed immediately after order was verified and confirmed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure dated 6/14 showed, Fluid Restriction . The nursing department and dietary department will ensure that the resident receives the prescribed amount of fluid . Inform all appropriate facility staff . Dietary documentation must reflect the number of cc (ml) intake ordered from the physician and the amount of cc (ml) intake the resident is receiving from the dietary department and the nursing department .

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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** 34891 Based on observation, interview, and record review the facility failed to ensure pressure relieving interventions were in place for 2 of 6 residents (R57, R20) reviewed for pressure ulcers in the sample of 35. The findings include: 1. R57's face sheet printed on 10/31/24 showed diagnoses including but not limited to multiple sclerosis, diabetes mellitus, protein-calorie malnutrition, peripheral vascular disease, stage 4 pressure ulcer to the sacral region, left leg above the knee amputation, and history of osteomyelitis. R57's facility assessment dated [DATE] showed severe cognitive impairment and requiring total staff assistance with all activities of daily living. The same assessment showed the use of an indwelling catheter and R57 is always incontinent of bowel. The assessment showed the use of a feeding tube for nutrition. R57's physician order report showed she was admitted to hospice on 10/13/24. R57's wound evaluation report dated 10/17/24 showed stage four pressure ulcers to the sacrum, right hip, and left buttock. R57's weight summary noted provided by the facility on 10/31/24 showed a weight of 75.4 pounds. On 10/29/24 at 11:25 AM, R57 was lying in bed and asleep. A pressure reducing mattress was under her and the control box was hung on the foot of the bed. The dial on the box was set just below the 320 mark. At 11:28 AM and 1:56 PM the dial was in the same position. On 10/30/24 at 10:46 AM, R57 was in bed and the control dial was in the same position, just under 320. At 1:48 PM, catheter care was performed by V8 (CNA-Certified Nurse Aide). The dial was still in the same position. V8 stated he checks on R57 and repositions her every two hours. V8 stated R57 has pressure ulcers on her back side and needs the air mattress to help with healing. On 10/31/24 at 8:34 AM, V5 (Wound Care Nurse) and V7 (CNA) performed dressing changes to R57's pressure ulcers. V5 (WCN) stated R57 has the dressings changed each day and as needed. V7 (CNA) stated hospice set up R57's pressure reduction mattress and decides where the control dial should be set. V7 observed the dial near the 320 mark and said that usually represents the resident's weight. V7 said it was unclear why it was currently set so high and R57 definitely does not weigh 320 pounds. On 10/31/24 10:19 AM, V18 (Registered Nurse) performed a feeding tube flush for R57. V19 (Hospice CNA) was at the bedside and finishing nail care with R57. The air mattress control dial was set just under the 320 mark. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 9:45 AM, V9 (Wound Physician) stated he sees R57 weekly until the recent hospice admission. He now sees her every other week. V9 said R57 is steadily declining and has chronic wounds to her back side. V9 stated the air mattress should be set according to the resident's weight and 320 seems too high for her. There is the potential for delayed wound healing or development of more open skin areas. V9 stated she has a lot of other health issues, so it is doubtful the incorrect dial setting is affecting her much, but the potential is there. On 10/31/24 at 10:05 AM, V2 (Director of Nurses) stated pressure reduction mattresses should be checked by the restorative and floor CNAs. Aides should be inspecting the mattress daily and during all cares. Aides should ensure the control box lights are on and the settings are appropriate. Any concerns should be reported right away. If the dial is set too low or too high, the mattress is not providing the correct amount of pressure relief. All resident air mattresses should be checked and set according to each individual's current weight. The facility supplied an undated operation manual related to R57's air mattress. The manual stated: Pressure set up-Users can adjust the pressure level of the air mattress to a desired firmness by themselves or according to the suggestion from a health care professional. 38488 2. R20's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, hypertension, hyperlipidemia, vascular dementia without behavioral disturbance, dysphagia, cerebral atherosclerosis, and paranoid schizophrenia. R20's facility assessment showed he has moderate cognitive impairment and requires substantial to maximum assistance with all cares. R20's care plan initiated 9/30/2014 showed, The resident has potential for pressure ulcer development related to immobility; incontinence . Interventions: . Foam boots bilateral feet while on bed for preventative . Follow facility policies/protocols for the prevention of skin breakdown . On 10/29/24 at 10:27 AM, R20 was lying in bed. R20's legs were both contracted and his heels were directly on his mattress and there were no pillows placed between R20's knees and ankles. R20's left hand was contracted and his finger nails were pushing into his palm. On 10/29/24 at 10:34 AM, V5 (Wound Care Nurse) assessed R20's heels and left hand. R20's left heel was reddened. V5 confirmed R20's fingernails were pressed into his palm. On 10/31/24 AM at 9:02 AM, V15 CNA said R20 should have heel protector boots to prevent pressure ulcers. On 10/31/24 at 10:57 AM, V7 CNA (Certified Nursing Assistant) said R20 is turned every two hours either on back or towards the window and they make sure he is clean and dry. On 10/31/24 at 1:04 PM, V2 DON (Director of Nursing) said R20's heels should be floated or heel boots should be in place for pressure prevention. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure dated 9/14 showed, Pressure Ulcer Prevention; Purpose: To prevent and treat pressure sores . 11. Use positioning devices to relieve the pressure from heels, toes, knees, and ankles. Prevent direct contact between bony prominences .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to accurately assess a resident with contractures and failed to ensure a hand splint was in place for a dependent resident with contractures for 1 of 1 residents (R20) reviewed for splints in the sample of 35. The findings include: R20's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, hypertension, hyperlipidemia, vascular dementia without behavioral disturbance, dysphagia, cerebral atherosclerosis, and paranoid schizophrenia. R20's facility assessment showed he has moderate cognitive impairment and requires substantial to maximum assistance with all cares. On 10/29/24 at 10:27 AM, R20 was lying in bed. R20's left hand was contracted. R20 had no splint on his left hand/wrist. On 10/29/24 at 10:34 AM, V5 (Wound Care Nurse) and V20 CNA (Certified Nursing Assistant) was assessing R20. When V5 was attempting to open R20's hand to clean dried up food from his palm R20 was complaining of pain and saying ouch ouch. V5 and V20 were having difficulty repositioning R20 and when they would try to move his legs he complained of pain. R20's bilateral knees and left hand were contracted. On 10/31/24 at 9:02 AM, R20 was lying in bed. R20 said he does not have a splint for his hand or boots. R20 said he had a splint before and he wore it. On 10/31/24 AM at 9:02 AM, V15 CNA said R20 used to have a splint and she thinks the therapy department is trying to figure out where it went. R20's 10/5/24 Restorative Assessment signed 10/5/24 showed all range of motion was within normal limits and showed R20 did not use a splint or brace. R20's 10/5/24 Restorative Assessment signed 10/31/24 (during the annual survey) showed R20 had mild to moderate loss of range of motion to his left shoulder, left elbow, left wrist and fingers, left hip, right hip, left knee, and right knee. R20's complete care plan was reviewed and showed no evidence of his left upper extremity splint. R20's 7/3/24 Physician Progress note showed, . Impaired ADLs . generalized weakness and LUE (left upper extremity) and BLE (bilateral lower extremity) contractures: LUE resting hand splint functional position . R20's 10/18/24 Physician Progress note showed, . LUE Resting hand splint functional position/reordered today . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's October 2024 Physician Order Sheet showed an order dated 10/16/24 for, LUE Resting hand splint/functional position. Dx: LUE contracture . The facility's faxed order to the company that provides the splint was reviewed and showed an order was written 10/16/24 and faxed to the company 10/29/24 (while the surveyors were in the facility). The last 3 months of splint application documentation was requested and none was available. On 10/31/24 at 9:14 AM, V16 (Restorative Aide) said they are ordering R20 a splint because his has been missing for 1-2 months. V16 said she or V21 (Restorative Nurse) would be the one ordering the splint. V16 said the order would be entered into the resident's record and then faxed to the company that provides the splints. V16 said the splint for R20 would be for management of his left hand contracture. On 10/31/24 at 9:18 AM, V21 (Restorative Nurse) said he does a hands on assessment of each resident quarterly to identify any changes in their functioning. V21 said he documents his assessment in the electronic record. V21 said, The thing is we found it before and then it got lost again so we have to order a new one . On 10/31/24 at 12:54 PM, V2 DON (Director of Nursing) said the splint application should be documented in the record by the CNA's. V2 said the Restorative Assessments are done quarterly and are meant to direct restorative programs suited for each individual resident and their capabilities. The facility's policy and procedure dated 9/14 showed, Restorative Nursing Policy & Procedure . To prevent further loss of independence . To promote wellness and prevent debilitation. Includes but is not limited to, programs in walking/mobility, dressing and grooming . splint or brace assistance . A licensed nurse supervises the restorative nursing programs . Documentation of the interventions and the resident's response will be completed with each implementation . The facility's policy and procedure dated 4/14 showed, Activities of Daily Living . To preserve ADL function, promote independence and increase self-esteem and dignity .Upper Extremity Orthotic (splint) . Apply splint safely and with correct positioning . follow schedule for application and removal.

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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** 39543 Based on observation, interview, and record review the facility failed to accurately assess a resident for smoking safety, failed to implement safe smoking interventions, and failed to accurately assess a resident for community pass. This applies to 3 of 10 residents (R33, R90, R91) reviewed for safety in the sample of 35. The findings include: 1. R33's Admission Record (Face Sheet) showed an admitted [DATE]. The face sheet showed a diagnosis of paranoid schizophrenia. R33's 9/26/24 Quarterly Minimum Data Set (MDS) showed severe cognitive impairment with a Brief Interview for Mental status score of 5 out of 15. The MDS showed he had disorganized thinking, hallucinations, delusions, physical behavioral symptoms directed toward others (1 to 3 days a week), and verbal behavioral symptoms directed toward others (1 to 3 days a week). On 10/30/24 at 9:36 AM, the front desk sign-out sheet showed R33 had signed himself out on pass at 8:55 AM and returned at 9:27 AM. R33's 10/19/24 Nursing Note from 9:38 AM showed, Was informed by PRSC (Psychiatric Rehabilitation Services Coordinator) resident was drinking out of bleach bottle. This writer and PRSC went promptly to resident room and tried to take the bleach bottle but refused. He said it is cola. He poured it into a cup and drink it. He said that he rinsed it first before putting the cola [in the bottle]. Educated resident that drinking cola out of bleach bottle is not safe. He was aggressive and continues not to listen . On 10/31/24 at 8:56 AM, V12 PRSC stated she responded to R33 drinking out of a bleach bottle. V12 said R33 can be aggressive, and he refused to hand over the bleach bottle. V12 said R33 is allowed to sign himself out on day pass and leave the facility. V12 said R33 is known to dig through garbage cans. V12 stated she believed R33 found the bleach bottle in a community garbage can while he was out of the facility. V12 said the community assessment, in the facility's electronic health record system, and the Minimum Data Set's (MDS) Brief Interview for Mental Status (BIMS) score (a measure of cognitive ability) are tools used to determine if residents are safe to exit the facility on community pass. V12 said the assessment provides a score which is used to determine their level of safety. V12 said the assessments are done quarterly and whenever there is a change in the residents' condition. V12 said the purpose of the assessments are to ensure the residents are safe in the community and they are not a hazard to themselves or others. The facility's Preliminary Incident Investigation Report Form showed R33 assaulted his roommate on 9/12/24. The report showed R33 punched R28 in the head and R28 suffered laceration to his left and right eyebrow. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 11:39 AM, R28 stated he was urinating and he had missed the toilet. R28 said R33 then poured water on the urine, and without provocation, began punching him in the face. R33 stated R28 is an aggressive person and has attempted to punch him before. R33's 10/3/24 Nursing Note from 9:57 PM showed, Resident broke the glass in the dining area of the first floor. He is redirected and he is sitting quietly in the corner of the dining room R33's 10/2/24 Nursing Progress Note from 12:01 AM, showed This writer and the 2300 NOC (11:00 PM Night) nurse went inside the elevator going to the second floor and this resident went up with us and started calling this writer and the other nurse bastard . R33's Community Survival Skills assessment dated [DATE] (last documented assessment as of 10/30/24) showed, 1. The resident is sufficiently alert, oriented, coherent, and knowledgeable allowing him/her to be considered for independent outside pass privileges. (If Yes continue with assessment and you must answer questions 2-10; if No skip question 2-10 and proceed to the recommendations section and check 'Not Capable' The report showed, 4. The resident appears able to refrain from self-harmful and/or socially inappropriate behavior while in the community. The report continued, 6. The resident has knowledge of potentially dangerous situations, such as walking alone after dark, straying into an alley, accepting ridge from strangers, carrying valuable items where they are easily seen. The tenth and final question in the assessment showed, The resident sufficiently follows rules addressing medication compliance, participation in his/her treatment plan, appropriate hygiene and grooming, and treats others with respect. Question 1, 4, 6, and 10 were answered in the affirmative indicating he had met the requirement. The assessments finding was, The resident appears to be capable of outside pass privileges at this time. On 10/31/24 at 12:01 PM, V14 Registered Nurse stated R33 is difficult to redirect, he is easily agitated, and aggressive at times. V14 said he has been sent out of the facility for evaluation for hitting staff and residents. On 10/31/24 at 11:05 AM, V4 PRSC stated he is assigned to R33, and he completed the community pass assessment. V4 stated residents are allowed to leave the facility on community pass based on their assessment and BIMS score. V4 said the BIMS score of 5 would indicate poor cognition; however, it may not fully describe a resident's cognition if they refuse to answer. V4 said, he was not in the facility when the incident with the bleach bottle occurred, and he was just made aware of the incident. (V4 stated, on 10/31/24 at 2:18 PM, he was not aware of R33 drinking out of a bleach bottle.) V4 said R33 is known to be aggressive and not easily redirected. V4 said R33 has hit a resident as well as CNAs (Certified Nursing Assistants). V4 said R33 is also known to dig through garbage. V4 stated the purpose of the community assessment is to determine if a resident is safe in the community. V4 stated, based on R33's behaviors, he should have answered some of the community pass assessment questions differently. V4 said the facility is responsible for R33's safety while he is outside the facility and the purpose of the community assessment is to determine if residents are safe in the community. On 10/30/24 at 1:44 PM, R33 was outside the conference room window smoking unattended. He was stumbling on the uneven ground and using the brick facade of the building as support. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's Smoking Risk Review from 9/23/24 at 4:18 PM showed the assessment is scored as follows, 0 equals no problems; 1 is minimal problems; 2 is moderate problems; and 3 is severe problems. The Orientation/Cognition question of the assessment showed, If the resident is cognitively impaired and 2 or 3 is coded the resident should be placed on supervision or not permitted to smoke. R33's orientation score was a 2. R33's total score for the assessment was an 8. The Recommendation and Outcome section of the assessment showed residents who score between 4-18 May not be capable of handling/carrying any smoking materials and requires supervision when smoking. The assessment showed a free-text comment box which stated, Resident is compliant with smoking rules at this time. R33's Smoking Risk Review from 4/8/24 and 7/3/24 showed identical answers, identical scores, identical comments, and identical recommendations as the 9/23/24 assessment. On 10/30/24 at 2:18 PM, V4 stated he completes the smoking assessments for his assigned residents. V4 stated R33 is not well open to redirection and he doesn't have a good thought process, he's not open to redirection, and he can become aggressive if you try to redirect him. V4 said, It's not worth the risk to try and take away his smoking materials and place him on supervision; it's not feasible with his aggressive behaviors. If we said (told R33), you can only smoke at certain times and with supervision then he would probably have an episode at that point. The purpose of the assessment is to determine if they are safe or not to have smoking materials and smoke without supervision. I would agree, based on the assessment, he is not safe to have his smoking materials or smoke unsupervised. Interviews with R33 were attempted on 10/29/24 at 2:00 PM and 10/31/24 at 11:45 AM; R33 refused. The facility's Smoking Policy (Revised 6/20/23) showed, All residents will be assessed for compliance at minimum of every three months and with renewal of contracts/forms as needed. The facility's Community Pass Policy (dated 4/2014) showed, Purpose: To define the facility and resident's responsibility when a resident leaves the facility with the consent of the facility. The policy showed, A 'Community Skills Assessment' will be completed by Social Services upon Admission, Quarterly, or as appropriate with changes in cognitive or functional ability. If appropriate, the resident will be given an overnight pass. 20042 2. On 10/30/24 at 1:48 PM, R90 was sitting outside in a chair on the back patio. Where R90 was sitting was around the corner and behind the building. R90 had a long, brown, thin cigar in his hand that was lit and he was smoking. V4 PRSC (Psychiatric Rehabilitation Services Coordinator) was outside with two containers with tobacco products and lighters. V4 stated stated some residents cigarettes/cigars are labeled and in here. V4 stated they hand the smoking materials out. V4 stated R90 was not someone they have deemed as needing to have them hold onto his thin cigars. V4 stated R90 came outside with his cigar. V4 was asked if R90 has been caught smoking in his room and V4 replied he didn't know anything about that but is sounded right. V4 stated when a resident is caught smoking in their room the smoking materials are taken away and education is given. V4 stated education really wouldn't work for R90. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Service Note dated 7/30/24 at 4:22 PM, for R90 showed, resident was caught smoking inside his bathroom; two packs of cigarettes and a lighter were confiscated from this residents room; resident was educated on the smoking policy and how dangerous it is to smoke inside the facility; resident is already on restricted community access; resident will continue to be educated and monitored. The MDS (Minimum Data Set) dated 9/25/25 for R90 showed, a BIMS (brief interview of mental status) score of 4 - severe cognitive impairment. The Smoking Risk Review dated 9/25/24 for R90 showed a score of 8. A score of 4-18 showed, may not be capable of handling/carrying and smoking materials and requires supervision when smoking. The comments on the form showed, Resident is a smoker. Resident has a history of smoking in his room. The Care Plan Note dated 9/25/24 written by V4 showed, resident is a smoker and has many reports of smoking inside his room. Will continue with goal. R90's Care Plan dated 10/17/24 showed, resident is an independent or appropriate smoker with no smoking policy violations in the past 3 months or more (level 1). Maintenance of following facility smoking policy, remaining safe, and not endangering self, other residents or staff. Resident will not be allowed to hold his own smoking materials. The Face Sheet dated 10/31/24 for R90 showed diagnoses including dementia, severe protein calorie malnutrition, hyperlipidemia, iron deficiency, chronic ischemic heart disease, major depressive disorder, hypertension, bipolar disorder, and non-ST elevation. The facility's Smoking Policy - Residents (6/20/23) showed, facility will require holding smoking materials for all residents who are not considered to be independent smokers. All smokers who have violated the smoking policies will be required to meet with caseworkers to discuss safety issues regarding smoking and placed on the smoking program. All smokers will be care planned to allow for consistency in consequences associated with inappropriate smoking or violating facility's policies (including giving, selling, or buying of smoking materials for other individuals). All residents will be assessed for compliance at a minimum of every three months and with the renewal of contracts/forms as needed. Every resident will be educated, counseled, and trained in safe smoking and will be placed on the least restrictions as possible while maintaining safety to self and others. 38488 3. R91's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include alcoholic cirrhosis of liver, hypothyroidism, recurrent depressive disorders, anxiety disorder, insomnia, chronic pain, and hepatic encephalopathy. R91's facility assessment dated [DATE] showed he had no cognitive impairment. On 10/29/24 at 10:16 AM, R91 he is a smoker and he keeps his own smoking materials because he can go down and smoke whenever he wants. On top of R91's nightstand there was a package of cigars and a lighter. R91's 6/13/24 Smoking Risk Assessment showed, . Resident has reports of smoking in his room . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R91's 9/4/24 Smoking Risk Assessment showed, Resident has reports of smoking in his room .May not be capable of handling/carrying any smoking materials and requires supervision when smoking. (score 4-18) - Resident's score 14. R91's 9/3/24 Care Plan Note showed, Resident has history of smoking in room. None reported this quarter. Social services holds on to cigarettes for resident. R91's 7/1/24 Social Service Note showed, There was a report of resident smoking in bathroom .asked resident who denied having smoked in bathroom. There was a slight smoke smell in bathroom. Room search was conducted and no smoking materials were found. Will continue to monitor. R91's 6/28/24 Social Service Note showed, . got a report that the resident was smoking in his room . did a room search but found nothing, room had a light scent of smoke. Resident denied smoking. Will continue to monitor and revise if needed. R91's 3/14/24 Nursing Progress Note showed, Resident got agitated when he got caught smoking in his room . The facility's policy and procedure with revision 6/20/23 showed, Smoking Policy - Residents . Facility will require holding smoking materials for all residents who are not considered to be independent smokers .

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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** 38488 Based on observation, interview, and record review the facility failed to provide catheter care for a resident with a suprapubic catheter for 1 of 3 residents (R30) reviewed for catheters in the sample of 35. The findings include: R30's face sheet showed he was admitted to the facility 7/2/2018 with diagnoses to include spina bifida, Type 2 Diabetes, iron deficiency anemia, hyperlipidemia, hypokalemia, neuromuscular dysfunction of bladder, Major Depressive Disorder, need for assistance with personal care, and hypo-osmolality and hyponatremia. R30's facility's assessment dated [DATE] showed he has no cognitive impairment and requires supervision through maximal assistance for cares. R30's care plan initiated 1/11/2019 showed, Indwelling Catheter . Interventions: (1/11/2019)Catheter care every shift during routine CNA care . 7/15/21 Educate resident on catheter care and maintenance . (4/15/2019 Monitor suprapubic site for drainage, redness, pain . (7/15/21) [R30] may change the foley rain bag per himself as per his request . R30's October 2024 Physician Order Sheet showed an order dated 10/17/24 for Catheter: clean suprapubic catheter site daily on 11-7 shift and as needed. R30's October 2024 eMAR (electronic Medication Administration Record) showed an order for Bactrim DS to be given two times a day for a UTI (urinary tract infection) starting 10/18/24 through 10/25/24. On 10/29/24 09:43 AM, R30 said he has a catheter and takes care of it himself most of the time. R30 said the staff are supposed to take care of he does it to try and help them. R30 said he washes the catheter with soap and water every day. On 10/31/24 at 10:51 AM, V21 CNA (Certified Nursing Assistant) said R30 usually takes care of emptying his catheter himself and cleaning it throughout the day. V21 CNA said if staff notice his catheter bag is too full they will dump it. On 10/31/24 at 10:58 AM, V7 CNA said R30 self manages his catheter for them. V7 said they make sure R30 puts it in a privacy bag but otherwise that's it. V7 said R30 empties his catheter himself. On 10/31/24 at 11:07 AM, V14 RN (Registered Nurse) said R30's catheter needs to be changed the 15th of every months and the night nurse is supposed to change the dressing to the catheter site. V14 said the CNAs should empty the catheter. He does most of the care himself. The CNAs see to it that he is in the shower and that he is safe there. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 12:35 PM, V2 DON (Director of Nursing) said, For the most part, he wants to take care of the catheter himself, he wants to maintain his independence. Its not all the time that he does it but the staff still pretty much does it for him. That is the first I have heard of him cleaning it himself. If he does it, it is on his time and I'm not aware of that. We leave it open to air after cleaning. We discourage him from doing that but he still does it. I have talked to him personally myself not to touch it himself . No training has taken place, I wouldn't approve of that. The facility's policy and procedure for Urinary Catheters was requested and not received.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 20042 Based on observation, interview, and record review the facility failed to ensure the oxygen tubing was connected to the oxygen concentrator for the delivery of as needed oxygen to 1 of 1 resident (R48) reviewed for oxygen in the sample of 35. The findings include: On 10/29/24 at 10:13 AM R48 was sitting bed with the head of her bed elevated. R48 complained of being a little short of breath. R48's nasal cannula as hanging off the side of the bed and was not attached to the oxygen concentrator that was turned on. R48 stated she removed it to blow her nose. V3 RN (Registered Nurse) checked R48's oxygen saturation and it was 89% on room air. V3 placed the nasal cannula back in R48's nose and stated she would be back to check her oxygen saturation and left the room. V3 never checked R48's oxygen/concentrator to ensure the resident received the oxygen via nasal cannula. V3 was asked to check R48's oxygen; she returned to the resident's room. V3 was shown R48's nasal cannula and it not being attached to the oxygen concentrator. V3 stated the only way R48 would get any oxygen was if the cannula was plugged into the concentrator. The Physician Order Summary Report dated 10/31/24 for R48 showed, oxygen 3 liters/minute via nasal cannula as needed to keep oxygen saturation above 92%. On 10/31/24 at 8:35 AM, V3 DON (Director of Nursing) stated, if a residents needs oxygen or has an as needed order for oxygen it is usually to keep the oxygen saturation greater than 92%. If a resident is short of breath staff should administer oxygen. The nurse should check to see if the oxygen is working or not. They should make sure the nasal cannula is plugged into the concentrator. The resident's head of bed should be elevated and staff should check the appearance of the resident for example their color, nail beds, etc. The Care Plan dated 8/23/24 for R48 showed, the resident presents with altered respiratory function secondary to: chronic obstructive pulmonary disease. Observe & report signs of congestion, lethargy, labored breathing, wheezing, etc. Give 3L oxygen NC (nasal cannula) to keep O2 (oxygen) above 92% as ordered by physician. The facility's Oxygen Therapy policy (9/19) showed, give oxygen per physician order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 20042 Based on observation, interview, and record the facility failed to ensure medications were not left at a residents bedside and medications were given on time for 3 of 7 residents (R133, R153, & R90) reviewed for medications in the sample of 35. The findings include: 1. On 10/29/24 at 9:44 AM, R133 was asleep on his right side in bed. There was a medication cup with 4 oblong pills in it sitting on the dresser at the end of his bed. On 10/29/24 at 9:50 AM, V3 stated she was going to give R133 his medications right now and has not given him any medications today. V3 stated they are to watch the resident take their medications to make sure they take the medication. V3 stated medications can't be left at the bedside. V3 stated the nurse needs to make sure the resident takes the medication and they take it at the right time. On 10/30/24 at 9:44 AM, V2 DON (Director of Nursing) stated medications should not be left at bedside because it is not safe, other residents could take it. V2 stated that also means the resident did not take the medication. The Face Sheet dated 10/31/24 for R133 showed diagnoses including intracranial injury, morbid obesity, depressive disorders, anxiety disorder, cerebral infarction, chronic obstructive pulmonary disease, and history of falling. The MDS (Minimum Data Set) dated 9/4/24 showed moderate cognitive impairment. The Care Plan dated 9/6/24 for R133 showed, the resident requires psychotropic medication to help manage and alleviate. The present psychotropic medication regimen related to other recurrent depressive disorders and anxiety disorders, unspecified. Carry out all medication management regimen as prescribed. Alteration in comfort secondary to chronic leg pain. Give medications as ordered. R133's Care plan did not show a plan in place for self-administration of medications. The facility's Medication Administration Policy (8/15) showed, medications must be administered in accordance with the physicians' order at his/her discretion, e.g., the right resident, right medication, right dosage, right route, and right time. Medications should always be prepared, administered, and recorded by the same licensed nurse. Resident's may self-administer medication if the interdisciplinary team has determined that this practice is safe. 2. On 10/29/24 at 10:00 AM, V3 RN (Registered Nurse) gave R153 gabapentin 400 mg and depakote 500 mg by mouth. The October 2024 MAR (Medication Administration Record) for R153 showed the depakote was scheduled to be given at 8:00 AM and 8:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Face Sheet dated 10/31/24 for R153 showed diagnoses including major depressive disorder, bipolar disorder, anxiety disorder, attention-deficit hyperactivity disorder, and unspecified convulsions. On 10/29/24 at 10:04 AM, V3 RN gave R133 xanax 1 mg, depakote 500 mg, gabapentin 600 mg by mouth. The October 2024 MAR for R133 showed his xanax 1 mg, depakote 500 mg, and gabapentin 600 mg was to be given at 8:00 AM, 2:00 PM, & 10:00 PM. The Face Sheet dated 10/31/24 for R133 showed diagnoses including intracranial injury, morbid obesity, depressive disorders, anxiety disorder, cerebral infarction, chronic obstructive pulmonary disease, and history of falling. On 10/29/24 at 10:13 AM, V3 RN gave R48 gabapentin 600 mg and dicyclomine hcl 10 mg by mouth. The October 2024 MAR for R48 showed the gabapentin 600 mg and dicyclomine hcl 10 mg was to be given at 8:00 AM, 12:00 PM, and 4:00 PM. The Face Sheet dated 10/31/24 for R48 showed diagnoses including cerebral infarction, left side hemiplegia/hemiparesis, osteoarthritis, rheumatoid arthritis, depression, anxiety, insomnia, emphysema, asthma, irritable bowel syndrome, history of pulmonary embolism, chronic respiratory failure with hypoxia, and history of other venous thrombosis and embolism. On 10/30/24 at 9:44 AM, V2 DON (Director of Nursing) stated medications can be given one hour before or one hour after the scheduled time. V2 stated this was important to make sure the efficacy is maintained. V2 stated medications should not be given two hours late. The Medication Administration Policy (8/15) showed, medications must be administered in accordance with the physicians' order at his/her discretion, e.g., the right resident, right medication, right dosage, right route, and right time.