STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145465	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jerseyville Nsg & Rehab Center	1001 South State Street Jerseyville, IL 62052

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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 0686 Level of Harm - 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** 33112 Based on observation, interview, and record review, the facility failed to assess/monitor, provide treatments as ordered, and provide pressure relief to prevent pressure ulcers for 1 of 2 residents (R30) reviewed for pressure ulcers in the sample of 52. This failure resulted in R30 developing two facility acquired unstageable pressure ulcers to R30's left and right heels, and a Stage II pressure ulcer to his buttocks. Findings include: R30's Face Sheet, undated, documents R30 was admitted on [DATE], and has diagnoses of left femur fracture and hypertension. R30's Minimum Data Set (MDS), dated [DATE], documents R30 is moderately cognitively impaired and requires substantial / maximal assistance for staff for activities of daily living and mobility. R30's Braden Assessment, dated 1/12/24, documents R30 is a mild risk for developing pressure ulcers. R30 did not have an updated Braden Assessment after her return from the hospital on 1/27/24 with a fractured left hip. R30's Physician Orders, dated 1/28/24 - 2/28/24, documents, Heel protectors at all times. Start date of 2/1/24. R30's Physician Order Report, dated 1/28/24 - 2/28/24, documents, Start date of 2/27/24. Cleanse R (right) heel with wc (wound cleanser), apply betadine and LOTA (leave open to air). R30's Treatment Administration Record, documents, Start date of 2/9/24. Discontinue date of 2/22/24. Cleanse R (right) heel with wc (wound cleanser), apply betadine and LOTA (leave open to air). R30's February 2024 Treatment Administration Record did not document a treatment for R30's right heel pressure ulcer from 2/23/24 through 2/28/24. (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 0686 Level of Harm - Actual harm Residents Affected - Few	R30's Nurse's Note, dated 02/01/2024 at 1:27 PM, documents, 0900 This nurse assisting with res (resident) care, removed (anti-embolism stockings) due to soiled, noted a purple fluid filled blister to left heel, measuring 9 cm x 8 cm, no drainage present, blister intact. Heel protectors put into place, new order to skin prep blister TID (three times daily) and PRN (as needed), monitor for blister opening. Right buttock has sheering area noted measuring 4 cm x 1.5 cm, pink in center, no drainage present, new order to apply barrier cream TID and PRN for incontinence, monitor for worsening. (V33, Nurse Practitioner) NP notified. Res has no pain when asked. There was no documentation regarding a pressure ulcer to R30's right heel. R30's Wound Note, written by V17, Wound Doctor, dated 2/22/24, documents, Site 1 Unstageable (due to necrosis) of the right heel full thickness pressure ulcer measuring 4 x 3.5 with thick adherent black necrotic tissue 100%. Recommendations: Float Heels in Bed'; Off- Load Wound; Multipodus boot to use when out of bed. Dressing Treatment Plan: Primary Dressing Betadine apply once daily for 30 days. Site 2 Unstageable (due to necrosis) pressure ulcer of the left heel full thickness pressure ulcer measuring 5 x 5 x 0.1 cm. with 95% thick adherent black necrotic tissue and 5% granulation tissue. The progress of this wound and the context surrounding the progress were considered in great depth today. Reviewed off-loading surfaces and discussed surfaces care plan. Recommend upgrading off-loading devices in bed and/ or chair. Recommendations: Off-Load Wound; Float heels in bed; Pressure Off- Loading Boot; Multipodus boot when out of bed. Dressing Treatment Plan Primary Dressing. Gauze island w/ bdr (with border) apply once daily for 30 days. Betadine apply daily for 30 days. To heel eschar.; Leptospermun honey (medi - honey) once daily for 30 days: To granulating area. Site 3 Stage 2 Pressure Ulcer of the buttocks, measuring 3 x 1 x 0.1 cm, no exudate, open areas with dermis. Dressing Treatment Plan Primary Dressing House barrier cream apply twice daily and as needed for 23 days. R30's Nurse's Note, dated 02/23/2024 at 10:05, documents, Resident seen by wound physician. New order received: Cleanse wound with wound cleanser, apply betadine to eschar, medihoney to granulating area, cover with dry dressing. Resident and family aware of new orders. The Nurse's Note did not document which pressure sore was receiving the new treatment. R30's Nurse's Note, dated 02/27/2024 at 11:56, documents, Routine wound care being provided. Barrier cream no longer effective to area to L buttock due to drainage. (V17, Wound Doctor) notified, and new order received to cleanse wound to L (left) buttock with wound cleanser, apply calcium alginate and dry drsg (dressing) q (every) d (day)and prn. Resident and POA (Power of Attorney) aware of new orders. Wound measurements 1.1cm x 0.9cm at this time, scant to moderate amount of serosanguinous drainage noted. Updates noted in wound management. R30's Nurse's Note, dated 02/27/2024 at 17:57, documents, New order placed per (V17). to Cleanse area to R (right) heel, apply Betadine and LOTA q daily. Resident and POA aware. R30's Wound Note, written by V17, dated 2/29/24, documents no changes to R30's heel pressure ulcers, R30 left buttock pressure ulcer has moderate serous exudate and 60% dermis and subcutaneous tissue, and the wound progress of not at goal. On 2/26/24 at 12:00 PM, R30 was sitting up in wheelchair with no heel protectors on. On 2/27/24 at 8:53 AM, R30 was sitting up in wheelchair in room with no heel protectors on just slipper socks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/27/24 at 12:03 PM, R30 was sitting in wheelchair with heel protectors on. On 2/28/24 at 8:25 AM, R30 was sitting in wheelchair with no heel protectors on. On 2/27/24 at 10:50 AM, V14, Licensed Practical Nurse and V15, Registered Nurse, entered R30's room to provide pressure ulcer treatment to R30's left heel. V14 and V15 stated R30 had a pressure ulcer on his left heel, a shear area to his upper buttock, and the upper buttock just gets barrier cream. V14 removed the old left heel dressing. The dressing had yellowish brown drainage on it. The wound was cleansed with normal saline. The pressure ulcer was approximately 5.5 centimeters (cm) x 5 cm. An area at the top of the wound has a wound bed that is a small area of granulation tissue. The rest of the pressure ulcer was necrotic, hard, and black. The wound was treated with medihoney and betadine, then a dry dressing and gauze. R30 then was rolled onto his right side and his incontinent brief was removed. R30 had a pressure area approximately 3 cm x 1 cm. The wound bed is white. The brief had yellow drainage where the pressure area was. V14 stated she will put barrier cream on it. V15 who saw the wound stated, It's a Stage 2 pressure ulcer now. We need to let IV2, Director of Nursing/DON) know so she can look at it. V14 did not observe or treat the pressure ulcer on R30's right heel. On 2/27/24 at 11:15 AM, V2 stated she did look at R30's buttocks; the wound had worsened and she was going to call the wound doctor and get a doctor's order. V2 did not mention R30's pressure ulcer to right heel at that time. On 2/27/24 at 3:15 PM, V2 entered R30's room to look at R30's right heel. R30's was lying in bed. R30 did not have heel protectors on. R30's right sock was removed. R30's right heel pressure ulcer is approximately 4 cm x 3 cm. The pressure ulcer is necrotic, hard, and black. On 2/27/24 at 1:10 PM, V14, Licensed Practical Nurse/LPN, stated she was unaware R30 had a pressure ulcer on the right heel because she reviewed the orders before she did his treatment earlier, and there was no order for R30's right heel. On 02/27/24 at 1:20 PM, V2 stated R30 should have an order for Betadine daily for the right heel unless she accidently deleted it. On 2/27/24 at 3:15 PM, V2 stated R30 did get the heel pressure ulcers while in the facility. V2 stated, After he came back from the hospital because of a broken left hip, (R30) laid on his back with his heels on the mattress and staff were kinda afraid of his left leg because the hip was broken. The policy Wound Management Program, dated 2/26/21, documents, the facility will assess residents weekly for current skin conditions. The facility provided document What is a pressure Ulcer, undated, which documents, Pressure ulcers develop when there is injury to the skin and underlying tissue due to pressure for an extended period of time. This constant pressure reduces the blood supply to that area, preventing the delivery of vital nutrients and oxygen. Pressure ulcers most commonly occur in patients confined to a wheelchair or a bed. It continues, What can I do to prevent a pressure ulcer? Reposition yourself while in bed at least every 2 hours, in a chair at least every hour. Elevate you heels off the bed using a pillow under your lower legs.

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on observation, interview and record review, the facility failed to provide foot care, including providing current treatment and consulting with a Podiatrist for further treatment, for 1 of 1 resident (R31) reviewed for foot care in the sample of 52. This failure caused R31 to be in severe pain and have a severely reddened, swollen, and very tender fourth toe and/or foot for a long period of time. Findings include: R31's Face Sheet, undated, documents R31 was admitted to the facility on [DATE], and has diagnoses of arthritis, left hip, corns and callosities. R31's Care Plan, revised 1/10/24, documents R31 has potential/actual impairment to skin integrity related to, hypertension, history of falling, unspecified abnormalities of gait and mobility, tremor, dementia, anxiety, ambulates without assistants, fragile skin due to natural aging process. The Care Plan Approach, revised on 10/2/23, documents Weekly skin checks per licensed nurse. Document skin check in EMR (electronic medical record). 2) Treatment as per orders. The Care Plan Approach documented staff should report any red or open areas to the charge nurse. R31's Minimum Data Set (MDS), dated [DATE], documents R31 has a severe cognitive impairment, uses a wheelchair as a mobility device, is dependent on staff for sit-to-stand, and tub/shower transfers, requires substantial/maximal assistance from staff for toileting, bathing, dressing, personal hygiene, bed mobility, chair/bed-to-chair transfers, and toilet transfer. R31's Podiatry Note, dated 3/9/23, documents, Apply skin prep to 4th toe left foot QID (four times a day) X 4 weeks or longer until healed, no shoe B/L (bilateral/left) feet, cut a hole in left shoe. R31's Physician Order, dated 8/15/23, documents, Patient has corn on Left 4th toe. Make sure she will be seen by Podiatrist at facility when he comes next. See if there is a way, he can give nurses order between visits to keep corn under control. R31's Physician Order, dated 11/24/23, documents Check Left foot 4th toe q shift. Cleanse with wound cleanser and apply betadine/ Band-Aid to skin corn. Every Shift. This order was Discontinued on 2/12/24 by V5, Registered Nurse/RN. R31's Nursing Note, dated 1/19/24 at 8:04 AM, documents, Resident had a scheduled Care Plan 01-17-2024 with family. All concerns were addressed, family was happy with all care, resident will continue to be monitored, any changes will be made in next Care Plan meeting. There were no wound notes seen in R31's electronic medical record. R31's Medication Administration Record (MAR), dated 2/1/24 through 2/29/24, documents Check Left foot 4th toe q (every) shift. Cleanse with wound cleanser and apply betadine / Band-Aid to skin corn. Every Shift. This has not been signed off as completed since 2/11/24. (continued on next page)

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	145465	A. Building B. Wing	03/11/2024

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F 0687 Level of Harm - Actual harm Residents Affected - Few	On 2/26/24 at 9:10 AM, R31 was sitting in chair with her shoes and socks on. R31 stated her toes hurt when she touches them on anything, and especially when the staff are putting her shoes and socks on. R31's left shoe does not have a hole in it and is securely tied to R31's foot. On 2/27/24 9:55 AM, V12, R31's Daughter, stated, I visit my mom (R31) twice a day. Mom has a sore on one of her toes on left foot. I take pictures of it and check it every time I come in, and I can tell you that no one is doing anything with it. I had a Care Plan meeting and brought this to their attention, and still nothing is being done. I brought it up to the MDS Nurse (V3), and he said it looks like the treatment is getting done because it is charted, but I assure you, nothing is getting done. I have watched staff put mom's shoes on and she cries in pain every time. I am here to put mom to bed in the evening and her toe never has a band-aid on it or has been treated with Betadine, which I thought they were supposed to be doing. On 2/28/24 at 9:40 AM, V12 stated R31 was seen a year ago by a podiatrist and has not been seen since. V12 took off R31's left shoe and sock to show R31's left toes. Upon taking off her shoe and sock, R31 was grimacing in pain. R31 accidently hit her toes on the footrest of her wheelchair and grimaced and said Ouch. R31's left fourth toe was very crusty, swollen, red and painful to touch. The surrounding toes were also reddened, swollen, dry and crusty. On 2/28/24 at 9:45 AM, V3, MDS Nurse, stated Yes, (R31) is supposed to get a band-aid on her toe daily and I assumed it was getting done. On 2/28/24 at 9:50 AM, V2, Director of Nursing (DON), was brought into R31's room to see R31's toe, along with V12. V2 stated, It definitely looks tender. I wasn't involved in the Care Plan meeting and have not been told about (R31's) toe. No one has left me notes about it, and I haven't seen anything noted about it in her chart. The old ADON (Assistant Director of Nursing) was doing wounds on the day shift, and he no longer does that, and works the evenings now. I am the one doing wounds now, and I knew nothing about (R31's) toe. I know every wound in the facility and I am not sure that (R31's) toe is a wound, it is not open, just dried up. I will have the wound doctor see (R31) tomorrow to make sure we get the right treatment for her. Her toe looks like it does because it has not been treated. R31's Nursing Note, dated 2/28/24 at 10:20 AM, documents, NP (Nurse Practitioner) notified that daughter requesting res (resident) to have tx (treatment) again to corn on right fourth toe of cleansing with wound cleanser, applying Betadine and covering with band-aid. New orders received for this from NP who also inquired if daughter would like a referral for consult to (V32, Podiatrist) at (local hospital) and daughter stated she would. R31's Nursing Note, dated 2/28/24, at 10:30 AM, documents Left fourth toe cleansed with wound cleanser, betadine applied and covered with band-aid. No opened or draining areas noted. Res has hard, raised corn from mid-left side of toe which daughter states res has had for a long time-that she used to put betadine on it for a few days at a time when she took care of resident at home. No redness or warmth noted to left fourth toe or surrounding area. Res voices no c/o's pain during treatment. On 2/28/24 at 11:25 AM, V5, Registered Nurse (RN), stated, I was the one who discontinued (R31's) order for the treatment to her toe. I discontinued the order because it had been going on for a long time without any changes. No, I don't think she has been seen by a physician for her foot since the last time. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	The facility's Wound Management Program, dated 2/26/21, documents, It is the policy of (this facility) to manage resident skin integrity through prevention, assessment, and implementation and evaluation of interventions. Procedure: 1. The facility is provided with Wound Care Protocols. These are to be utilized to assist in the care and treatment of wounds. This reference tool can be placed in the front of the treatment administration record book or the weekly skin assessment book. Physician orders should be obtained and followed for each resident.

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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** 33112 Based on observation, interview, and record review, the facility failed to put progressive interventions in place and provide supervision to prevent falls for 2 of 3 residents (R30, R31) reviewed for falls. This failure resulted in R30 falling and sustaining a fractured hip, and R31 falling and sustaining a fractured arm. Findings include: 1.R30's Face Sheet, undated, documents R30 was admitted to the facility on [DATE], with diagnoses of Pneumonia, Hypertension and Shortness of Breath. R30's Nurse's Note, dated 01/04/2024 at 1:33 PM, documents, Patient arrived via (local) Emergency Medical Services with 2 attendants. Patient was in ER (emergency room) for two days, diagnosis fall. Patient had multiple unwitnessed falls at home. R30's Fall Risk Assessment, dated 1/4/24, documents R30 is a high fall risk. R30's Care Plan, initiated on 1/4/24, documented R30 was at risk for falls related to generalized weakness, forgets limitations, hearing impaired, unsteady gait, and occasional incontinence, Pathological fracture, left femur edited on 2/11/24. The Care Plan approaches, dated 1/4/24, were created by V2, Director of Nursing (DON). The Care Plan approaches were as follows: Use proper assistive device wheelchair/walker as needed; Rest periods as needed, Observe for safety; invite/escort to activities of choice as tolerated as desired; and Cues/redirect as needed. These approaches were entered into R30's Care Plan on 1/29/24. R30's Care Plan approach, dated 1/4/24, created by V2 on 2/7/24 documented, Call light within reach while in room and remind resident to call for assistance as needed, and clutter free environment. These approaches were entered into the Care Plan on 2/7/24. R30's Nurse's Note, dated 01/21/2024 at 10:46 PM, documents, CNA (Certified Nurse) witnessed resident on knees on the floor in the praying position sitting upright. resident stated he needed blue jeans, resident had grippy socks on at time of fall. Upon RN (Registered Nurse) assessment resident was at normal baseline, vitals noted all WNL's (within normal limits) in fall event, resident had no s/s (signs/symptoms) of pain/discomfort at this time. resident had no visible bruising/skin alterations at this time. POA (Power of Attorney) called, voicemail was left at 9:10 pm, DON/MD (Director of Nurses / Medical Doctor) notified. R30's Event Report for fall on 1/21/24, documented, Conclusion with root cause: Root cause analysis suggests resident was cold and trying to get warm by getting blankets. R30's Nurse's Note, dated 01/26/2024 01:30, documents, Called to room per CNA. Res observed laying on left side in front of personal bathroom. Bed in low position. Grippy socks on. Incont (incontinent) of BM (bowel movement). Res A&O (alert and orientated) x 2. Neuro (neurological) check WNL (within normal limit). Grips equal and strong. L (left) knee rotated inward. Complaining of moderate L hip pain and requesting to go to hospital. On call, (V35, Medical Doctor), notified and gave new order to send res to ER for eval (evaluation) and tx (treatment). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R30's Nurse's Note, dated 01/26/2024 07:17, documents, (local hospital) called and reported that patient has left hip fx (fracture), CT (cat scan) done of head due to latent hematoma that presented at hospital, it was negative. R30's Hospital Discharge Summary, dated 1/27/24, documents, Left hip fracture s/p (status post) surgical repair. R30's Fall and Investigation Event Report, dated 1/29/24, documents, Conclusion with root cause: Res (resident) up without assist and was incont (incontinent) of BM (bowel movement). R30's Care Plan approaches, start date of 1/26/24, created by V2 on 1/29/24, documented PT/OT (Physical Therapy/Occupational Therapy) to eval (evalutate) and treat; and call light reminder sign placed in resident room. There was no documentation of what type of supervision R30 needed by staff in the care plan. R30's Care Plan was not updated until 1/29/24 by V2 and documented, Staff to encourage and offer toileting and give additional blankets while in bed for warmth. In the medical record, there was no documentation that he facility reassessed R30 for need for supervision to prevent falls. R30's Nurse's Note, dated 02/01/2024 at 1:31 PM, documents, 1130 Res visually observed with knees on floor, in kneeling position with upper half of body on bed. Res assisted back into bed with 2x staff, LLE (left lower extremity) stable during transfer. PROM WNL (passive range of motion within normal limits), res denies pain to LLE or pain anywhere. No rotation noted to LLE. Pedal pulse present. Res incontinent of bladder, grippy socks with heel protectors in place, bed was in low position. No injuries noted. VS (vital signs) noted. Res did not have call light on, spoke with ST (speech therapy) whom is working with res for cognition, she is going to provide a visual aide sign for reminder of call for resident. (V33, Nurse Practitioner) notified. Res had been toileted approximately 1hr prior to this event. 1245p Res up in w/c (wheelchair) for lunch, ate 50% and drank fluids, propels self in hallway. Res denies pain when asked. R30's Care Plan was not updated after this fall. R30's Nurse's Note, dated 02/04/2024 10:44 AM, documents, Writer called to patient's room, patient observed on bedside mat on knees with bed in lowest position and upper body leaning onto bed. Patient stated that he put self in that position to relieve hip pain. Patient states he is not hurt did not fall onto floor, slid onto knees. ROM in WNL for this patient. 98.2 (temperature) 70 (pulse) 18 (respirations) 32/68 (blood pressure) 96% (oxygen saturation level) on RA (room air), Pain medication given at this time. Patient is sitting at nurses' station at this time. R30's Nurse's Note, dated 02/05/2024 10:29 AM, documents, IDT (Interdisciplinary Team) team met and reviewed falls. (R30) is at risk for falls r/t (related to): Generalized weakness, forgets limitations, hearing impaired, unsteady gait, and occasional incontinence, Pathological fracture, left femur. (R30) has had multiple falls: unwitnessed fall 1/21/24 unwitnessed fall 1/26/24 unwitnessed fall 2/1/24 unwitnessed fall 2/4/24. Discussed resident attempting self-transfer out of bed often, raised edge mattress placed on bed. Family updated. Fall mat remains in place to reduce injury. Call light reminder sign in place to remind resident to call for assistance with transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R30's Fall and Investigation Event Report, dated 2/7/24, documents, Conclusion with root cause: Resident forgets to call for assistance. Fall mat placed beside bed to reduce harm if resident attempts to get out of bed. R30's Care Plan approach, with start date of 2/4/24, created by V2 on 2/7/24 documented, Raised edge mattress placed on bed. There was no documentation regarding fall mat. On 3/7/24 at 9:52 AM, V20, Certified Nurse Aide, CNA, stated she took care of R30 before he fell , and he had got sick to his stomach and vomit on himself. V20 stated, The next day when I came back to work, they told me he had fallen and broke his hip. I think he didn't feel good and was trying to get up. He was confused but he would get himself up. At that time, he did not have any fall prevention interventions those did not go into place until after he broke his hip. 44967 2. R31's Face Sheet, undated, documents R31 was admitted to the facility on [DATE], with the diagnoses of Displaced fracture of coronoid process of right ulna, subsequent encounter for closed fracture with routine healing, dislocation of right ulna-humeral joint, dementia, anxiety, emphysema, dysphagia, vertigo, perforation of tympanic membrane, left ear, hearing loss, bilateral, arthritis, left hip, and a history of falling. R31's Care Plan, dated 10/28/22, documents R31 is at risk for falls due to diagnosis of tremors, vertigo, dementia, arthritis of left hip, pain in left and right knee, history of falling, and poor safety awareness related to Basic Interview for Mental Status (BIMS) of 8, up ad lib in facility with walker. The Care Plan documents R31 fell on [DATE], 9/27/23, 12/1/23, 12/8/23, and an unwitnessed fall on 2/10/24. Care Plan approaches with approach start dates are as follows: (2/10/24) Place resident in common areas for increased supervision; (2/10/24), Physical Therapy (PT)/Occupational Therapy (OT) to evaluate and treat; (12/8/23) Continue with antibiotic for ear infection, ear Infection contributes to poor balance; (12/1/23) Encourage resident to take frequent rest periods and staff to provide stand by assist when ambulating with walker; (10/17/23) Ensure the resident has on proper footwear such as non-skid socks or rubber sole shoes, (9/27/23) Staff to check on resident hourly; (7/23/23) Alarm declined by resident and Power of Attorney (POA) due to possible agitation; (7/21/23) Medication review, Norco discontinued, (7/20/23) R31 refuses to utilize gait belt with ambulation, education provided to resident and POA, and place visual reminder in room and verbally remind as needed to utilize walker for ambulation; (3/17/23) R31 may not report when she falls, daughter to assist in reporting to staff if fall is indicated, is up ad lib with walker, attempt to keep clear path and remove obstacles as needed to promote safety, encourage R31 to utilize walker when ambulating; (11/13/22) Attempt to keep bathroom light on and leave bathroom door open, and (10/28/22) Increased staff supervision as needed, keep frequently used items within reach, keep floor free of clutter, utilize half side rails as indicated, assessment and treatment for postural/orthostatic hypotension with falls, order comprehensive medication review by pharmacist, assess for polypharmacy and medications that increase the fall risk, implement exercise program that targets strength, gait and balance. R31's Admission Fall Risk Assessment, dated 10/29/22, documents R31 is a high fall risk. R31's Fall Risk Assessment, dated 1/3/24, documents R31 is a high fall risk. R31's Fall Risk Assessment, dated 2/10/24, documents R31 is a high fall risk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145465	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jerseyville Nsg & Rehab Center	1001 South State Street Jerseyville, IL 62052

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R31's MDS, dated [DATE], documents R31 has a severe cognitive impairment and is dependent on staff for sit-to-stand and tub/shower transfer, requires substantial/maximal assistance from staff for toileting, bathing, dressing, personal hygiene, bed mobility. R31's Fall Investigation, dated 12/1/23, documents, Description: Unwitnessed Fall in resident's room. What was resident doing just prior to fall? Sitting up in chair in room. Pain observation: Yes, mild pain to right hip. Interventions: Analgesics, rest, reminders to use call light. Conclusion with root cause: Resident wandering in hallway and around room and redirected frequently during NOC (hours sleep). Resident standing at window looking out blinds several times tonight looking at the rain. Found on floor in front of window with walker in use at time of fall. Treatments: Monitor for latent injuries related to recent fall. Evaluation Notes: Resident is a [AGE] year-old female who becomes weak at times. Encourage resident to frequent rest periods and staff to provide stand by assist when ambulating. R31's Fall Investigation, dated 12/8/23, documents, Description: Unwitnessed fall in resident's room. What was resident doing just prior to fall? Resting per bed. Pain observation - Yes to wrist. Positioning of extremities: Skin tear to left posterior wrist. Interventions: First Aid. POA refused interventions offered - no interventions used. Conclusion with root cause: Resident has an ear infection which contributes to balance issues. Continue on ABT (antibiotics). Evaluation Note: Continue with ABT for ear infection which as cause balance issues. R31's Fall Investigation, dated 2/10/24, documents, Description: Unwitnessed fall in resident's room. What was resident doing just prior to fall? Sitting in chair in room. Location of injury: Upper extremity - RUE (right upper extremity). Positioning of extremities: LROM (limited range of motion) to RUE - resident will not move due to pain. Possible contributing factors: Recent change in medications - placed on ABT (antibiotics) for left ear infection recently 12/9/23. Interventions: Sent to (local hospital emergency room - returned with fracture and arm sling. Conclusion with root cause: Resident has had frequent ear infections which may affect balance and a-fib. Resident has fractures to RUE. PT (Physical Therapy)/OT (Occupational Therapy) to evaluate. Will place resident in common areas for increased supervision. will follow up with (V30, Orthopedic Physician) (ortho on 2/15). Evaluation: Resident seen by NP. R arm remains bruised and swollen. Will follow up with (V30) on 2/15. R31's Nursing Note, dated 2/10/24 at 2:52 PM, documents [Recorded as Late Entry on 02/12/2024 03:30] Nurse called to resident room at 1552 (3:52 PM). (R31) observed in floor lying flat on back with head up against bathroom door. Nurse completed full assessment; no visible injuries noted. Resident c/o (complained of) moderate to severe pain to R (right) arm. LROM (limited range of motion) noted. No obvious injury to area, but resident unable to move R upper extremity and tearful. Full ROM (range of motion) noted to BLE (bilateral lower extremity), no internal or external rotation noted. CNA and this nurse remained at bedside. Neuros WNL (within normal limit) for resident baseline. VSS (vital signs stable). R31's Nursing Note, dated 2/10/24 at 10:46 PM, documents, Resident returned back from ER with Family. Dx (diagnosis) of dislocated shoulder joint and fractures of the coronoid process and radial head/neck are noted. Resident has sling to right arm. Had several doses of Morphine in ER with last dose at 10pm. She is to follow up with (V30, Orthopedic Physician) on Monday and continue with Tylenol for pain. Family here and requested a tray for (R31). Given at this time. (continued on next page)

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	145465	A. Building B. Wing	03/11/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R31's Nursing Note, dated 2/13/24 at 10:02 AM, documents, Res (resident) was a 1 x assist for transfer this AM, confusion noted. Right arm in sling, right hand has edema noted, radial pulse present, Ace wrap in place to right arm with soft splint. Ace wrap removed from lower portion and rewrapped due to it was tight. Res has f/u (follow up) on 2/15 at 14:00 per NP (Nurse Practitioner). NP to be in this afternoon to round on resident, notified of edema. Pillow and blanket rolled up to for positioning of right arm and elevated. Res (resident) c/o (complained of) pain to right arm this AM, took scheduled Tylenol. R31's MDS/Change in Condition, dated 2/21/24, documents R31 has a severe cognitive impairment and is dependent on staff for sit-to-stand, and tub/shower transfer, requires substantial/maximal assistance of staff for all other Activities of Daily Living (ADLs). R31's Nursing Note, dated 2/29/24 at 7:42 AM, documents, Resident sitting up in wheelchair. Band-aid in place to L 4th toe, tx (treatment) completed early am by noc (night) nurse. Brace in place to R arm r/t fx (fracture). Pulses present/neurovascular WNL. No c/o pain or distress noted. Resident requires stand-by assist for transfers/ambulating to bathroom, remains continent most of the time. Alert to self, confused to time and place and requires frequent redirection. Family here at this time to visit. Cont (continue) with therapy as ordered. Awaiting wound consult with (V32, MD). On 2/26/24 at 9:10 AM, R31 was sitting in a chair in her room with no staff present in the room. R31's call light was seen on the bed and not within reach of R31, restroom door is closed, sign posted Always remember walker. There was no other way to determine if R31 is a fall risk was seen. On 2/27/24 9:55 AM, R31's Daughter, stated, I visit my mom (R31) twice a day. She has been here over a year now. Mom has fallen about six times since she's been here. The biggest one was when they found her on the floor, it looked like she was coming out of her restroom and landed on her right side. She dislocated her elbow and fractured it in two places. They sent her to ER (emergency room) and then back with a brace. Due to her medical conditions, they did not want to do surgery. They did place mom by the nurse's desk at one time, but that was just as bad, because there is no one there to watch her either. On 2/27/24 at 2:25 PM, R31 was sitting in her chair by bed, wheelchair next to her, walker next to wheelchair, no staff seen in or around her room. R31 was not visible by anyone unless passing the room. R31's restroom door was closed, no other fall interventions noted. R31 was not seen in the common areas for increased supervision. On 2/29/24 at 7:45 AM, R31 was walking around her room without using her walker or wheelchair while trying to hold onto the bed and wheelchair during her walk, with no staff present in room. R31's call light was tied to the bedrail. On 3/4/24 at 9:05 AM, R31 sitting in her chair in her room by herself. R31's wheelchair was by bed approximately two feet away. R31's call light was tied to bedrail and not within reach of R31. There was now a star on R31's name plate that was not there previously. (continued on next page)

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	145465	A. Building B. Wing	03/11/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/4/24 at 2:45 PM, V20, CNA, and V11, CNA, both stated they are not sure what the stars on the resident name plate means. V11 thought it had something to do with toileting of the residents. V20 stated the main problem at the facility is with communication, and in all the meetings, she tells the nurses and the DON that they need to communicate with the CNAs about who is a fall risk, and what we are doing with them. V20 stated R31 always falls, and she is not sure what interventions are in place to keep her from falling. The facility's Fall Prevention Management Policy, dated 3/15/18, documents, It is the policy of (this facility) to have a fall prevention program 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. We will develop a culture of safety to provide the Quality of Care and preventive services for each individual resident. Our Quality Assurance Program will monitor the program to assure ongoing effectiveness. Fall Prevention Program Components: 2. A visual prompt is placed on the name plaque by the entrance to the resident's room. This system provides staff a visual alert to monitor those at risk for falls. Standards: 2. A Fall Risk Assessment will be performed at least quarterly and after any fall incident. Standard Fall/Safety Precautions: 7. Residents will be observed approximately every two hours to ensure the resident is safely positioned in the bed or chair and provide care as assigned with the plan of care.

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	145465	A. Building B. Wing	03/11/2024

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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** 32874 Based on observation and record review, the facility failed to provide complete incontinent care for 1 of 3 residents (R15) reviewed for incontinent care in the sample of 52. Findings include: 1.R15's face sheet, dated 2/28/2024, documents a diagnosis of disorder of urinary tract system. R15's Minimum Data Set, MDS, dated [DATE], documents R15 is always incontinent of urine and is dependent on staff for toileting. On 2/26/2024 at 12:13PM, R15 was lying on back in bed. V6, Certified Nursing Assistant/CNA, and V7, CNA, entered room. Both V6 and V7 washed hands with soap and water prior to donning gloves. R15 was incontinent of urine as verified by V6 and V7. V6 rolled R15 towards the wall. V7 assisted with rolling R15 towards the wall. R15 was on right side. V6 then sprayed peri wash on wet washcloth and wiped from front to back, then put washcloth in soiled bag on bed. V6 did these 2 more times, then dried R15. V6 then rolled R15 to left side and cleansed left buttock and rinsed. V6 then placed R15 on her on back took washcloth from front to back, then placed washcloth in soiled bag, got another washcloth, sprayed on peri wash, cleansed left groin then right groin and inner thigh, then rolled back on right side and cleaned rectal area again dried and applied barrier cream. V6 did not separate labia during cleansing or cleanse R15's inner thighs. The facility's Perineal Care Policy, dated 7/2017, documents, The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident ' s skin condition. The following equipment and supplies will be necessary when performing this procedure: 1. Wash basin; 2. Towels; 3. Washcloth; 4. Soap (or other authorized cleansing agent); and 5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in the Procedure: 2. Wash and dry your hands thoroughly. 9. For a female resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area, wiping from front to back. (1) Separate labia and wash area downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.) (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia. (3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (Note: If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.) (4) Gently dry perineum. e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia. f. Rinse thoroughly using the same technique as described in e above. g. Dry area thoroughly.

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	145465	A. Building B. Wing	03/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33112 Based on observation, interview, and record review, the facility failed to date multi-use insulin pens and vials for 3 of 5 residents (R7, R33, R36) reviewed for medication storage in the sample of 52. Findings include: 1.On 2/26/24, the 200 Hall medication cart was reviewed, and the following was observed: R36's Lispro insulin pen has no date of when it was opened. R36's February 2024 Physician Orders documents, insulin lispro insulin pen; 100 unit/mL (milliliter); amt (amount): 10 units; subcutaneous Three Times A Day. R33's Levemir insulin pen has no date of when it was opened. R33's February 2024 Physician Orders documents, Levemir FlexPen (insulin detemir (determine) u (unit)-100) insulin pen; 100 unit/mL (3 mL); amt: 18 units; subcutaneous Once a Day. R7's Lispro multi-use vial has no date of when it was opened. R7's February 2024 Physician Orders documents, Humalog U-100 Insulin (insulin lispro) solution; 100 unit/mL; amt: Per Sliding Scale; If Blood Sugar is less than 70, call MD (Medical Doctor). If Blood Sugar is 71 to 150, give 0 Units. If Blood Sugar is 151 to 200, give 2 Units. If Blood Sugar is 201 to 250, give 4 Units. If Blood Sugar is 251 to 300, give 6 Units. If Blood Sugar is 301 to 350, give 8 Units. If Blood Sugar is 351 to 400, give 10 Units. If Blood Sugar is greater than 400, give 12 Units. If Blood Sugar is greater than 401, call MD. subcutaneous Before Meals. On 2/26/24 at 11:35 AM, V14, Licensed Practical Nurse, stated the insulin is only good for 30 days, and when you open an insulin pen or vial, it should always be dated. The policy storage of medication, dated 5/1/2018, documents, When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The Policy documented 1. The nurse shall place a date opened sticker on the medication and enter the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulation / guidelines. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 33112 Based on observation, interview, and record review, the facility failed to follow the meals recipe and use the proper scoop size to ensure residents are getting the proper amount of nutrition. This failure has the potential to affect all 52 residents residing in the facility. Findings include: The facility Diet Spread Sheet, dated 11/15/23, documents a #8 (1/2 cup) scoop should be used for mechanical soft and pureed meatloaf and mashed potatoes. [NAME] beans should be a 4-ounce spoodle, pureed green beans should be #16 scoop (1/4 cup), and purred diets should get a 2/3 slice of pureed bread. On 02/28/24 at 12:06 PM, V18, Cook, began to serve the noon meal. The meat loaf was one piece, the mashed potatoes, pureed green beans, and green beans were served with a #20 scoop (3-1/3 tablespoons), the pureed meatloaf was served with a #20 scoop, the ground meatloaf was served with a #16 scoop (1/4 cup). The pureed meals did not get any pureed bread. On 3/4/24 at 11:18 AM, V18 stated he did not know there were specific scoop sizes he was supposed to be using. On 3/4/24 at 11:21 AM, V19, Dietary Manager, stated she did not know where to find the scoop size on the scoops, and that is why they were serving the wrong portion size. The policy Standardized Recipes, dated 1/12, documents, 1. Standardized recipes will be used to prepare foods to assure adequate amounts available and consistently high - quality food products are served. It continues, Standard recipes should include: Ingredients, weight volume of each ingredient, serving size, Equipment or utensils to be used. 4. Recipes will be used by the cooks. The Long-Term Care Application for Medicare and Medicaid, dated 2/27/24, documents the facility has 52 residents residing in the facility.

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	145465	A. Building B. Wing	03/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33112 Based on observation and record review, the facility failed to store food products in a manner to ensure food quality and avoid cross contamination. This failure has the potential to affect all 52 residents residing in the facility. Findings include: 1. On 02/26/24 at 08:48 AM, the kitchen was entered. The dry storage sugar barrel has a measuring cup in it, freezer 3 had a box of open dinner rolls exposed to air, freezer 4 had a box of bread sticks open to air, and there were disposable foil pans on floor. On 02/28/24 at 11:45 AM, the kitchen was entered there was a 25 pound bag of panko bread crumbs on the floor. On 3/4/24 at 12:01 PM, V19, Dietary Manager, stated the measuring cups should not be left in storage containers, nothing should be on the floor and all foods should be securely sealed after opening the original packaging. The Dry Storage Areas policy, dated 1/2012, documents, Dry storage areas will be kept neat, orderly, and in a condition which protects foods in a safe and sanitary manner. Items will be stored at least 6 (inches) off the floor and 18 from the ceiling or from the sprinkler heads, whichever is further.

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	145465	A. Building B. Wing	03/11/2024

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32874 Based on interview and record review, the facility failed to implement a QAPI (Quality Assurance Performance Improvement) program and identify problems and implement interventions for issues identified. This failure has the potential to affect all 52 residents residing at the facility. Findings include : On 2/24/2024 at 3:20PM, V2, Director of Nursing (DON), stated the group does meet quarterly and involves herself, Medical Director, and all department heads. V2 stated the facility does not have a Performance Improvement Plan (PIP). V2 stated they just talk about stuff the facility needs to work on. V2 stated the facility had not identified Covid-19 infection as a problem, and the facilitiy does not have a Performance Improvement Plan. V2 also stated they do talk about things. The facility did not provide any type of QAPI improvement activities. On 03/04/24 at 12:17 PM, V4, Business Office Manager, stated there was a QAPI meeting held in January. (V36, Medical Director), came and did a full meeting in December or January. The QA meeting summary documented that Interdisciplinary Team (IDT) meeting was held on January 19, 2024 at 2:51PM, and a discussion was held with V36, Medical Director, regarding staffing, integrating new referral/admission processes, and new lab process. There was no documentation in regard to COVID-19 outbreak at the facility. The summary documented the pharmacy reports reviewed with MD regarding psychotropic medications. The QA meeting notes included a executive quarterly summary of consultant pharmacist medication regiment review, psychotropic and sedative hypnotic utilization trends. There was not a signature for the Director of Nursing on the sign in sheet for this meeting. The Quality Assurance and Performance Improvement (QAPI) policy, dated 10/28/2020, documented, The purpose of QAPI is to take a proactive approach to continually improving the way we care for and engage with guests, residents, caregivers and other partners. It continues, All employees will participate in ongoing [NAME] efforts which support the mission of offering a compassionate, unwavering commitment to customer service, continuous improvement of the facility clinical capabilities and outcomes and a commitment to use our resources and expertise to serve the needs of the customers. It continues, The written QAPI plan provides guidance for overall quality improvement program. QAPI principles will drive the decision making within the organization. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care and resident transition. Focus areas will include all systems that affect resident and family satisfaction, quality of care and services provided. and all areas that affect the quality of life for person living and working in the organization. It continues, The administrator will assure the QAPI plan is reviewed minimally on an annual basis by the QAA committee. Revisions will be made.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32874 Based on interview and record review, the facility failed to implement a QAPI (Quality Assurance Performance Improvement) activities, and identify problems and implement interventions for issues identified. This failure has the potential to affect all 52 residents residing at the facility. Findings include : On 2/24/2024 at 3:20PM, V2, Director of Nursing (DON) stated the group does meet quarterly and involves herself, Medical Director, and all department heads. V2 stated the facility does not have a Performance Improvement Plan (PIP). V2 stated they just talk about stuff the facility needs to work on. V2 stated the facility had not identified Covid-19 infection as a problem, and the facilitiy does not have a Performance Improvement plan. V2 also stated they do talk about things. The facility did not provide any type of QAPI improvement activities. The quality assurance and performance improvement policy, dated 10/28/2020, documented, The purpose of QAPI is to take a proactive approach to continually improving the way we care for and engage with guests, residents, caregivers and other partners. It continues, All employees will participate in ongoing [NAME] efforts which support the mission of offering a compassionate, unwavering commitment to customer service, continuous improvement of the facility clinical capabilities and outcomes and a commitment to use our resources and expertise to serve the needs of the customers. It continues, The written QAPI plan provides guidance for overall quality improvement program. QAPI principles will drive the decision making within the organization. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care and resident transition. Focus areas will include all systems that affect resident and family satisfaction, quality of care and services provided. and all areas that affect the quality of life for person living and working in the organization. It continues, The administrator will assure the QAPI plan is reviewed minimally on an annual basis by the QAA committee. Revisions will be made.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145465	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on observation, interview, and record review, the facility failed to implement a system to track and trend infections, failed to implement a system for testing for the spread of COVID-19, and failed to implement infection control procedures including isolation precautions and personal protective equipment (PPE) to prevent the spread of COVID-19. These failures resulted in 23 residents developing COVID-19, including 5 residents (R37, R51, R207, R208, and R209) who expired after becoming positive with COVID-19. Two residents (R19, and R40), and one staff member (V27, Certified Nursing Assistant/CNA) are currently positive with COVID-19. These failures have the potential to affect all 52 residents in the facility. The Immediate Jeopardy began on [DATE], when R35 developed COVID-19 and the facility failed to conduct testing and surveillance to prevent the spread of COVID-19. Subsequently, 22 other residents have developed COVID-19. Although the facility tested those with COVID-19 symptoms, the facility did not conduct testing for all residents and health care personnel identified as close contacts twice a week as per CDC guidance after these residents were diagnosed . Subsequently, R51 was diagnosed with COVID and expired on [DATE] with COVID and Congestive Heart Failure (CHF), R207 was diagnosed with COVID and expired on [DATE] with COVID, R209 was diagnosed with COVID and expired on [DATE] with Heart Disease, R208 was diagnosed with COVID and expired on [DATE] with Pneumonia and COVID, R37 was sent to the hospital and diagnosed with COVID on [DATE] and expired on [DATE]. On [DATE] at 2:15 PM, V2, Director of Nurses (DON), stated at the time R35 tested positive for COVID-19, there was no contact tracing done with residents or employees. On [DATE] at 8:53 AM, V1, Administrator, V2, Director of Nursing, and V3, MDS Nurse/Infection Control Nurse, V4, Business Office Manager/Admissions, and V37, Regional Director of Operations and Clinical Services (via phone), were notified of the Immediate Jeopardy. The surveyors confirmed by observation, interview, and record review, the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time was needed to evaluate the implementation and effectiveness of the in-service training. Findings include: 1.Upon entrance into the building on [DATE] through [DATE], there was no signage on the doors indicating any of the residents had COVID-19 or were on contact isolation. On [DATE], the facility provided a list of 18 residents in the facility including R13, R34, R18, R25, R17, R6, R207, R208, R42, R47, R32, R31, R3, R209, R7, R22, R2, and R210 who were positive with COVID-19 from [DATE] through [DATE], and no contact tracing or further testing was completed. During the investigation, there were three more residents (R35, R37, and R51) who were noted to have COVID-19 in the facility during that same time frame. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. R35's Face Sheet, undated, documents, R35 was admitted on [DATE], with diagnoses of Atrial Fibrillation and right sided heart failure. R35's Nurses Note, dated [DATE] 11:59 PM, documents, Res c/o (complaint of) new onset generalized weakness. Writer tested res (resident) for COVID and res is positive. Droplet isolation precautions initiated. Res assisted to bathroom and to bed. Educated res (resident) to use call light for assistance during NOC (night). V/S (vital sign) @ 98.3, 47, 18, ,d+[DATE], Sp02 (oxygen saturation) 96% ORA (on room air). NP (Nurse Practitioner) notified via fax. Left message for POA (Power of Attorney) to call facility. DON (Director of Nurses) notified. 44967 3. R207's Face Sheet, undated, documents R207 was admitted to the facility on [DATE], with diagnoses of fracture of unspecified part of neck of right femur, COVID-19 acute respiratory disease, depression, hypertension (HTN), chronic kidney disease-stage 3, and cerebral infarction. R207's Nursing Note, dated [DATE] at 8:56 AM, documented, Patient has excess nasal drainage with cough noted in dining room. Brought out of dining room and tested for COVID, patient was positive at this time. POA (Power of Attorney) was notified. NP (Nurse Practitioner) was notified and responded with orders for anti-viral Lagevrio 200mg give 4 caps BID (twice daily) x 5 days, ASA 81mg daily x 30 days from positive test, vital signs every shift x 10 days, and Mucinex 600mg BID x 10 days. Lungs are clear at this time. 97.8 89 18 ,d+[DATE]. 93%. R207's Nursing Note, dated [DATE] at 6:29 PM, documented, Resident looks really bad. Fingertips blue, not eating and drinking. Notified son of situation. Resident refused to take medication. R207's Nursing Note, dated [DATE] at 9:21 PM, documented, Resident was found by CNA approx. 6:30pm stated that resident looked really bad and his fingertips were blue, and resident was not eating and drinking for dinner. CNA states that the previous nurse was notified prior. the nurse prior then notified POA son of resident change in condition. Resident is currently COVID +, upon assessing resident, resident appears to be uncomfortable and anxious, cyanotic at the lips and nailbeds, this nurse immediately obtained VS (vital signs) as a result, resident VS were unstable Spo2 84% RA (room air) resident immediately placed on 2L O2 with HOB (head of bed) elevated for comfort, HR (heart rate) ranging ,d+[DATE], Temp. 98.3, unable to access B/P (blood pressure) at this hour. Son is at bedside and is made aware of resident being on comfort care, notified the on call MD (medical doctor) for reinstatement of PRN (as needed) Lorazepam 2mg/mL 0. 25mL Q 4hr d/t (due to) anxiousness and Morphine Sulfate 5 mg/0.25ml PRN Q 4hrs for pain. MD returned call with okay to reinstate PRNs. Son made aware. R207's Nursing Note, dated [DATE] at 9:58 PM, documented, Called to room per CNA. Resident observed with no vital signs of life. No pulse or respirations noted. No heart or lung sounds on ausc. (auscultated) MD notified. Coroner, notified. POA notified. Administrator and nurse manager on call notified. New order received to release remains to (funeral home) in (nearby town). Postmortem care provided. R207's Death Certificate, dated [DATE], documents R207's cause of death was Palliative Care, CVA (cerebral vascular accident), and COVID-19. 4. R208's Face Sheet, undated, documented R208 was admitted to the facility on [DATE],3 with diagnoses of Chronic obstructive pulmonary disease (COPD), Pneumonia, COVID-19 acute respiratory disease, Dysphagia, Emphysema, Congested Heart Failure (CHF), Atherosclerotic heart disease (ASHD), and HTN. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R208's Nursing Note, dated [DATE] at 8:41 AM, documented, Patient had coughing episode in dining room, patient was taken out of dining room, where nasal congested was noted in excess patient expressed, he did not feel well. Patient was tested for COVID at this time, positive results. Lungs are congested. POA updated at this time. NP was notified and responded with orders to monitor vitals every shift, ASA 81mg x 30 days from positive date, anti-viral Lagevrio 200mg give 4 caps BID x 5 days and contact isolation x 10 days. 97.8 89 18 ,d+[DATE] 94%. R208's Nursing Note, dated [DATE] at 10:59 AM, documented, 0820 called to residents room, res was moaning, HOB elevated, respirations labored at 26 resp (respirations) per min. SPO2 78%, res had removed O2 from nose, placed back into place, at 4L/NC due to SOB (shortness of breath), spo2 83%. Lungs diminished in bilateral lower lobes, unable to assess upper lobes accurately due to res moaning. Wet cough present. Lips dry, res did continue to ask for a drink, he drank 120ml of water. 0845 911 notified of need of transfer and DON notified. 0850 Daughter notified. 0915 (local hospital) Ambulance service arrived, res transferred from bed onto stretcher using sheet. Res continued to pull O2 off and mask. 0920 Report called to RN at (local hospital) ER (emergency room), ED (emergency department) form, med list, face sheet, and POLST (Physician Orders for Life-Sustaining Treatment) form sent with EMTS (emergency medical technicians) R208's Nursing Note, dated [DATE] at 2:15 PM, documented, 1245 Res returned from (local hospital) ER via ambulance, res was on RA (room air) upon arriving, respirations are even and unlabored, res was moaning, but would answer when asked questions. VS 97.8 80 20 ,d+[DATE], unable to obtain a pulse ox with finger monitor. New orders: Decadron 6mg 1 tab PO (orally) daily x 5 days; to start on ,d+[DATE] and Augmentin 875mg 1 tab PO Q12h x 7 days for chronic bronchitis. Staff assisting res with lunch. R208's Nursing Note, dated [DATE] at 10:29 PM, documented, Standing comfort orders noted in MAR (medication administration record). R208's Nursing Note, dated [DATE] at 6:01 AM, documented, Upon entering residents room, resident appeared to be in an uncomfortable state with chest rise and fall equal bilaterally, POA at bedside for support. resident was due for schedule Morphine Sulfate. and Lorazepam at this hour, resident appearing to show s/sx (signs/symptoms) of distress with respiration of ,d+[DATE] that plummet to ,d+[DATE] while attempting to obtain vitals, Resident took last breath before administering schedule medication, while this nurse was at bedside, POA present in facility at the time of resident expiring. after assessing resident for 5 minutes resident is showing no signs of life or respiratory effort, has no palpable carotid pulse, has no heart sounds on auscultation, no respiratory sounds on auscultation, absence of pupillary reflexes and corneal reflex, and absence of motor response to supra-orbital pressure. This nurse provided privacy and notified [NAME] funeral home per family, corner notified, and MD notified. [SIC] R208's Death Certificate, dated [DATE], documented that R208's Cause of Death was Pneumonia, COPD, and COVID-19. 5.R209's Face Sheet, undated, documented that R209 was admitted to the facility on [DATE], with diagnoses of Chronic ischemic heart disease, atrial fibrillation, Sick sinus syndrome, Peripheral vascular disease, and stage 1 through stage 4 chronic kidney disease. (continued on next page)

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	145465	A. Building B. Wing	03/11/2024

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R209's Nursing Note, dated [DATE] at 11:30 AM, documented, Patient continues with poor appetite. Congested cough noted. Patient roommate positive for COVID. Patient tested and came positive as well. Patient currently on (local hospice). POA and (local hospice) notified of positive test and symptoms. No new orders at this time from (local hospice). Nurse will be in today to see patient. COVID orders per facility will be placed at this time. Vital signs every shift, droplet precautions. R209's Nursing Note, dated [DATE] at 10:36 AM, documented, 10:19 Called to residents room, res expired, no HR, BP, or respirations noted. 10:25 This nurse called POA and notified of res expired, she voiced no one would be coming to facility due to her herself having COVID. She confirmed (funeral home in nearby town) is whom they would be using. 10:36 Called placed to (local hospice), care notified of res expired at 10:19. Nurse is to be returning phone call. R209's Death Certificate, dated [DATE], documents R209's Cause of Death Ischemic Heart Disease. 32874 6. R37's face sheet, undated, documents a diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute respiratory failure, personal history of COVID-19. R37's progress notes, dated [DATE] at 3:43, documented, Resident observed with shortness of breath (SOB), congestion and wet lungs sounds, SP02 ,d+[DATE]% on 2liters of 02 per nasal cannula, Notes document nebulization treatment administered and SPO2 dropped to 50's. Head of bed elevated. Medical Doctor notified and POA notified. New order notes to send resident to emergency room for evaluation and treatment 911 called. R37's notes, dated [DATE] at 10:20, documented, Call placed to hospital for updates, notes document resident is COVID positive. Progress notes, dated [DATE] at 11:15, documented, Hospital called and gave report resident passed away. R37's hospital emergency room report, dated [DATE], documented, Date of service at 08:43 with reason for admission hypoxic respiratory failure/copd exacerbation. Chief complaint history and physical, dated date of service [DATE], documented, (R37) with a past medical history of COPD, congestive heart failure was brought to the ER by Emergency Medical Services (EMS) for complaints of shortness of breath and increased somnolence. (R37's) Emergency Report (ER) documents in the ED (R37) was found to be tachypneic sating low on room air. It continues, Treated with BIPAP, albuterol nebulizing treatment. Documents given one dose of diuretic. Despite Bipap treatment the patient continued to desat down into the 80%. Documents DNR/DNI. It continues, (R37) was then transferred to ICU on airborne isolation for further management. R37's notes documented throughout the morning, the patient became increasingly somnolent and when she would fall asleep, she would desaturate to ,d+[DATE]%. R37's report also documented when she was roused and coached by the nurse, her 02 sats would improve to the low 90% and this was needed with increased frequency. R37's death certificate documented R37 expired on [DATE] with the following diagnosis, Respiratory Arrest, Chronic Obstructive Pulmonary Disease (COPD) and COVID. 7. R51's face sheet, undated, documents a diagnosis of acute or chronic diastolic (congestive) heart failure (primary admission) and pneumonia. (continued on next page)

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	145465	A. Building B. Wing	03/11/2024

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R51's progress notes, dated [DATE] at 6:28, documented, Resident had sudden onset of Shortness of breath (SOB) RN raised head of bed 45 degrees, resident still could not catch breath. It continues, RN put resident on 2L (liters) of 02 per nasal cannula for comfort., resident subside right away and requested to keep o2 on. R51's progress notes, dated [DATE] at 12:22. Documented, (R51) will have a room move today, resident will be moving 230-b-308a due to positive covid isolation. Documents will continue to monitor. Any changes will be made next care plan meeting. [DATE] at 12:42 PM, R51's progress notes, documented, Nurse Practitioner (NP) here, new order to obtain covid test due to decline and SOB. Progress notes documents COVID test completed, positive results noted. Progress notes documents droplet isolation, Lagevrio 200 milligram(mg), give 4 caps by mouth (po) twice a day (bid) x 5 days Mucinex Extended Release (ER) 60mg 1 tab po x 10 days. R51's Progress notes document lungs have rubs to bilateral upper lobes 02 in place at 2l per nasal canula (nc). R51's notes, dated [DATE] at 3:00PM, documented, (R51) complained of SOB, requested a breathing treatment, this RN administered prn treatment per electronic medical record (emar). It continued, Resident stated treatment was effective and she is breathing much better. Resident is currently on 2 liters of 02, hob elevated, 02 sat is 94%, and lungs have rubs to bilateral upper lobes 02 in place at 2l nc. R51's notes, dated [DATE] at 15:00, documented, Resident on covid isolation, respirations even and unlabored. lying quietly in bed at present time. no acute distress noted this shift, daughter will be taking mom home tomorrow. R51's progress notes, dated [DATE] at 16:39, documented, Lungs diminished bilaterally; resident has congested sounding cough that's occasionally productive of cream colored phlegm. Progress notes, dated [DATE] at 10:05 AM, documented, CNA states upon entering room to get resident dressed, resident not to have any respiration. Resident expired at this time. R51's death certificate, dated [DATE], documented the cause of death as Congestive Heart Failure (CHF) Fractured Humerus, and COVID. 8.R40's Face Sheet, undated, documented that R40 was admitted on [DATE], and has diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Cardiac Arrhythmia and Type 2 Diabetes. R40's Physician Orders documented, Start date of [DATE] Droplet Isolation. Start date of [DATE] Ipratropium - Albuterol solution for nebulization; 0.5 mg (milligram) - 3 mg; amount 1 vial; inhalation. every 6 hours. dx (diagnosis) 2019- nCov (covid). Start date of [DATE] End date of [DATE] Lagevrio capsule 200 mg; amount 4 caps (capsules) Twice a Day. Dx 2019 nCov. Mucinex tablet extended release 12 hour; 600 mg; amount 1 tab; oral Twice a day. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R40's Nurses Note, dated [DATE] 1:31 PM, documented, Patient has complaints of congestion and cough. Patient lungs have bilateral crackles. SP02 (oxygenation saturation)-95% on RA (room air). NP (Nurse Practitioner) gave orders to obtain covid swab. COVID swab done x 3 swabs, all positive. Patient is being moved and droplet isolation precautions will be in place. New orders received for lagevrio 200mg, give 4 caps BID x 5 days, mucinex 600mg BID x 7 days, and duonebs q (every) 6hrs while awake. POA (Power of Attorney) made aware of diagnosis and room move. R40's Nurses Note, dated [DATE] 2:06 PM, documents, Resident had a temp. room move, due to positive covid isolation, family was made aware, resident moved from 234b-302a, resident will continue to be monitored, any changes will be in next care plan meeting. 9. R19's most current undated face sheet documents diagnoses of acute respiratory disease, Chronic obstructive pulmonary disease, and mild intermittent asthma. R19's care plan, dated [DATE], documented R19 has a tested positive for COVID-19. R19's care plan documents this places R19 at higher risk for severe illness. R19's progress notes, dated [DATE] at 20:09, documents R19 positive for COVID-19. R19's progress notes, dated [DATE], documents R19 is on antibiotics for pneumonia. On [DATE] at 10:05 AM, V31, Housekeeper, entered R19's room, which has isolation cart outside room and sign on door for transmission-based precautions. V31 did not sanitize hands prior to entering R19's room or don any Personal Protective equipment (PPE). V31 then exited room and did not sanitize hands, V31 then walked down hall and got floor sign from cart and sit out in hallway. On [DATE], V31 stated he is expected to don PPE prior to entering and isolation room. 10.On [DATE] at 8:45 AM, V16, Regional Nurse stated V27, Certified Nursing Assistant (CNA) tested positive for Covid 19 on [DATE] at home and positive at clinic on [DATE]. V16 stated V27 worked at the facility on [DATE] and returned to work at the facility on [DATE]. V27's employee timecard, dated [DATE]- [DATE], documents V27 worked 7:55AM -9:56PM on [DATE]. V27's timecard documents V27's next day of work as [DATE] at 5:29AM. V16, Regional Nurse stated she would have expected V27, CNA, to remain off work for 10 days. The facility was unable to provide any documentation the facility had implemented any type of contact tracing. On [DATE] at 9:57 AM, V3, MDS/ Infection Control Nurse, stated he started employment at the facility on [DATE]. V3 continued to state he has taken the infection control modules for certification, but he has not taken the test as he had not had time. V3 stated on [DATE], all residents and staff at the facility were tested and there were no positive cases of COVID-19. V3 stated all employees on duty were tested , and all employees who were not on duty will be tested prior to their shift. V3 stated he has not been in contact with the local health department regarding COVID 19 infection. V3 stated he has a roster of all employees, and is tracking testing on that roster. V3 stated he also has a list of all residents. V3 stated when R40 tested positive, he had a roommate, R47, and he did not test R47. V3 stated V4, Business Office Manager, put the current signage on the front door, which still does not document there is COVID-19 in the building. (continued on next page)

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	145465	A. Building B. Wing	03/11/2024

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 9:18 AM, per telephone interview, V34, Jersey County Health Department Infection Control Nurse, stated she has not been contacted by anyone at the facility, or made aware of any COVID-19 infection. V34 stated if the health department would have been contacted, she would have provided them a copy of the current IDPH guidance. V34 stated she would have discussed with the facility to provide additional staff education regarding handwashing. V34 stated signage on the door at entry should document the facility has COVID-19 in the building so visitors could be made aware of infection in the building. V34 stated she would expect the facility to be testing twice a week until no positives for 2 incubation periods. V34 stated the facility should be maintaining a line list of COVID-19 positive residents and submitting to the list to the health department on a weekly basis. V34 stated staff should be wearing gown, gloves, N95 masks, and face shield/or goggles when entering a COVID 19 positive room. On [DATE] at 10:58 AM, V2, Director of Nursing, stated she had not reached out to the local health department regarding COVID-19 infection. The QA meeting summary documented there was an Interdisciplinary Team (IDT) meeting held on [DATE], at 2:51PM, and a discussion was held with V36, Medical Director, regarding staffing, integrating new referral/admission processes, new lab process, but there was no documentation in regard to the COVID-19 outbreak at the facility recently. The facility policy, Screening: Residents, Health Care Personnel and Residents, dated [DATE], documented, The facility will put into place measures and processes to inform residents, visitors, and health care peroneal of recommended actions to prevent the transmission of COVID-19. It continues, The facility will post visual alerts at entrances and other strategic areas that include instructions about current infection prevention and control recommendations. This includes when to use source control and when to perform hand hygiene. It continues, Visitors- visual prompts will be posted to ensure visitors are aware of when their visitations should be limited or deferred including when they are infectious or potentially infectious or until they have met the health care criteria to end isolation to preserve the safety of the residents. It continues, Visitors should defer visits for the following: they have a positive viral test for SARS-COV-2, they have symptoms of COVID-19, they have close contact with someone with SARS-COV-2 infection, they have been in a situation that put them at high risk for transmission until 10 days after close contact. The facility policy, Healthcare Personnel Work Restrictions, dated [DATE], documented, The facility will implement appropriate work restrictions for Healthcare Personnel according to current regulatory guidance. It continues, Healthcare personnel with confirmed Covid-19 return to work criteria Covid 19 documents confirmed infection are excluded from work and may return to work based on the severity of their illness. The facility policy, Covid-19 testing plan, dated [DATE], documented, The facility will implement a testing plan to assist in preventing the transmission of COVID-19. The policy documents testing is required in the following instances: residents who are symptomatic regardless of vaccination status even if symptoms are mild as soon as possible, asymptomatic residents and health care personnel with close contract or higher risk exposure with someone with SARS_COV-2 infection (serial testing: series of 3 viral tests). It continues, If the facility is in outbreak status (immediately and twice weekly or very ,d+[DATE] days until no more positive cases for 14 days. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's Infection Prevention and Control Program Policies and Procedures: General Statement, dated , d+[DATE], documented, The organization has made a commitment to prudent infection prevention and control measures by promoting the concept of compassionate, common-sense resident and patient care, with an emphasis on cleanliness and infection prevention strategies. This organization has an established infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. We strive to implement evidenced based approaches to infection prevention. The infection prevention and control program: Investigates, controls, and prevents infections in the organization. Decides what procedures, such as isolation, should be applied to the individual resident/patient. Maintains a record of incidents and corrective actions related to infections. Has written procedures as a basis of determination for isolation (transmission based precautions) to help prevent the spread of infection. Has an employee health directive to prevent the spread of communicable diseases through work restriction and hand hygiene. The Immediate Jeopardy that began on [DATE], and was removed on [DATE], when the facility took the following actions: 1. V40, Medical Records, notified the facility's Medical Director, V36, of the Immediate Jeopardy. 2. Facility infection control policies were reviewed by Regional Nurse, V37, and V1, Administrator, to ensure it is acceptable with Standards of Practice and CDC Guidelines. 3. On [DATE], V2, DON, and V3, MDS Nurse, immediately assessed and tested all residents for COVID-19, and then tested all staff members immediately or prior to their next working shift for COVID-19. 4. On [DATE], V38, Corporate Infection Preventionist Nurse, trained V1, Administrator, V2, DON, V3, MDS Nurse, V4, Business Office Manager, and V22, ADON, on Vaccine and Reporting Policy, Screening of Resident and Healthcare Personal Policy, COVID-19 Plan Policy, Management of Residents with confirmed and suspected COVID-19 infection and transmittal-based precautions policy, and Healthcare personal work restriction policy. 5. On [DATE], all staff members were educated, via in-service, email, or phone call, by V1, V2, V4, and V38, regarding the facility's policy on COVID-19 required testing and monitoring including biweekly testing during outbreak status for staff and residents initiated on [DATE] and/or prior to the next working shift. No staff will be allowed to begin their scheduled shift prior to being educated in accordance with these policies and procedures. 1. Vaccine and Reporting Policy. 2. Screening of resident and healthcare personal policy. 3. COVID-19 testing plan policy. 4. Management of residents with confirmed and suspected COVID-19 infection and transmittal-based precautions policy. 5. Healthcare personal work restriction policy. 6. V3, MDS Nurse/Infection Preventionist, will review COVID testing log bi-weekly to ensure completion according to CDC guidelines and facility policy for four weeks and again when outbreak status occurs in the facility. 7. V38, Corporate Infection Preventionist, will be reviewing V3's audits upon completion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145465	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jerseyville Nsg & Rehab Center	1001 South State Street Jerseyville, IL 62052

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE], the survey team validated the removal of the immediacy by interviewing V14, LPN, V37, CNA, V39, CNA, V15, RN, V40 Medical Records Director, V41, Housekeeping Supervisor, V13, Activities Director, and V18, Cook, about the in-services they received related to the following policies and procedures: 1. Vaccine and Reporting Policy. 2. Screening of resident and healthcare personal policy. 3. COVID-19 testing plan policy. 4. Management of residents with confirmed and suspected COVID-19 infection and transmittal-based precautions policy. 5. Healthcare personal work restriction policy. The completed facility audits, in-services and policies were reviewed.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 44967 Based on interview and record review, the facility failed to designate a qualified individual(s) onsite, who is responsible for assessing, developing, implementing, monitoring, and managing the Infection Prevention and Control Program (IPCP) to prevent and control infections in the facility. This has the potential to affect all 52 residents living in the Facility. The Findings Include: On 2/28/24 at 2:11 PM, a Infection Control Meeting was held with V2, Director of Nursing (DON), V3, Minimum Data Set (MDS) Nurse, and V16, Regional Nurse. V16 stated V3 is the facility's Infection Control Preventionist, but is not certified yet. On 3/5/24 at 9:57 AM, V3 stated, I have taken the infection control modules for certification, but have not taken the test yet, because I do not have the time. The Facility's Infection Preventionist Policy, dated 10/2017, documented, The Infection Preventionist is responsible for coordinating the implementation and updating of our established infection control policies and practices. 1. The infection Preventionist (or designee) shall coordinate the development and monitoring of our facility's established infection prevention and control policies and practices. 2. The Infection Preventionist shall report information related to compliance with our facility's established infection prevention and control policies and practices to the Administrator and Quality Assurance and Performance Improvement Committee. 3. The Infection Preventionist shall keep abreast of changes in infection prevention and control guidelines and regulations to ensure our facility's protocols remain current and aid in preventing and controlling the spread of infections. 4. Upon approval from the Administrator, the Infection Preventionist may designate other employees to assist him/her in the performance of these duties. 5. The Infection Preventionist will collect analyze and provide infection and antibiotic usage data and trends to nursing staff and health care practitioners; consult on infection risk assessment and prevention control strategies; provide education and training; and implement evidenced-based infection prevention and control practices. The Resident Census and Conditions of Residents, CMS 671, dated 2/27/24, documents that the facility has 52 residents living in the facility.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 33112 Based on interview and record review, the facility failed to offer and provide COVID vaccines or boosters. This failure has the potential to affect all 52 residents residing in the building. Findings include: 1. R204's Face Sheet, undated, documents R204 was admitted on [DATE] with diagnoses of Vitamin deficiency. The facility is unable to provide documentation R204 was offered the COVID vaccine or boosters. 2. R42's Face Sheet, undated, documents R42 was admitted on [DATE] with diagnoses of Bacterial Pneumonia and has history of pneumonia and chronic rhinitis. The facility is unable to provide documentation R42 was offered the COVID vaccine or boosters. 3. R5's Face Sheet, undated, documents R5 was admitted on [DATE] with diagnoses of Alzheimer's disease, Type 2 diabetes mellitus and Hypertension. The facility is unable to provide documentation R5 was offered the COVID vaccine or boosters. 4. R43's Face Sheet, undated, documents R43 was admitted on [DATE] and has diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension and Diabetes Mellitus. The facility is unable to provide documentation R43 was offered the COVID vaccine or boosters. 5. R31's Face Sheet, undated, documents R31 was admitted on [DATE] and has diagnoses of Hypertension and Dementia. The facility is unable to provide documentation R43 was offered the COVID vaccine or boosters. 6. R208's Face Sheet, undated, documents R208 was admitted on [DATE] and had diagnoses of COPD, Pneumonia, and COVID. R208's Face Sheet documents R208 expired on [DATE]. R208's Death Certificate documents R208 cause of death was Pneumonia and COVID. The facility is unable to provide documentation R208 was offered the COVID vaccine or boosters. 7. R37's Face Sheet, undated, documents R37 was admitted on [DATE] with diagnosis of COPD. This Face Sheet also documents R37 expired on [DATE]. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R37's Hospital Record, dated [DATE], documents R37 was admitted to the hospital on [DATE] and discharged on [DATE]. R37's Hospital Discharge Diagnosis Documents Hypoxic Respiratory Failure with hypercapnic acidosis, COPD, not in exacerbations, and COVID 19. The facility is unable to provide documentation R37 was offered the COVID vaccine or boosters. On [DATE] at 2:35 PM, V16, Regional Nurse, stated the facility is not offering the COVID vaccine. The facilities pharmacy will not come into the building an immunize residents and staff unless the facility pays a large cost. We are working on setting up a process to be able to get residents vaccinated outside of the facility. We are thinking of getting van/bus to take residents to pharmacy to get the immunizations. We are working on getting our nurses certified to be able to give the vaccine. If a resident comes in without COVID vaccinations, the only way they would get it is if the family would take them out to get vaccinated. The policy COVID - 19 Resident & Staff Vaccination Policies and Procedures, dated [DATE], documented, Obtaining COVID - 19 Vaccine: COVID- 19 vaccine will be ordered from either the facility's LTC (Long Term Care) pharmacy or local or state public health agency. Facility will make arrangements with the vaccine provider to administer the vaccine to the staff and residents. Staff may receive the vaccine from community health sites. Offering the COVID - 19 Vaccine: Residents: COVID - 19 vaccinations/ boosters will be offered to all residents (directly or through their representative if they cannot make health care decisions) subject to CDC (Center for Disease Control), CMS (Central Management System) and / or FDA (Food Drug Administration) guidelines and physician orders. Residents are under no obligation to be vaccinated, and may accept, refuse, or change their minds as they or their representative wish. The Long Term Care Application for Medicare and Medicaid, dated [DATE], documents the facility has 52 residents residing in the facility.