STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145691	A. Building B. Wing	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare of Pekin	2501 Allentown Road Pekin, IL 61554

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41869 Based on observation, interview and record review, the facility failed to protect a resident's right to have their call light answered in a timely manner for four residents (R1, R2, R4 and R5) reviewed for call lights in a sample of eight. Findings include: The facility's Call Light Guidance policy dated 9/22/20 documents Resident call light shall be responded to within a reasonable amount of time. R1's minimum data set (MDS) documents a brief interview of mental status (BIMS) of 14. R2, R4 and R5's MDS documents a BIMS of 15. A BIMS of 12-15 indicates an individual is cognitively intact. The facility's Resident Council Minutes dated 8/29/23 and 10/30/23 documents Resident stated call light wait times are long. On 12/6/23 at 8:48 AM, R1 stated It would take the CNAs (Certified Nursing Assistant) two hours to answer my call light. I got tired of waiting for my call light to be answered one night so I transferred myself to the wheelchair and went out in the hallway and found a CNA sleeping. That explains why they take so long to answer the call light. On 12/6/23 at 9:15 AM, R5 stated It takes a long time for them to answer the call light. I would say up to an hour. On 12/6/23 at 9:30 AM, R2 stated Sometimes it may be an hour before they answer my call light. Most of the tine I sit here just waiting wondering how long it'll be today. On 12/6/23 at 9:35 AM, R4 stated Them answering my call light is a joke. It takes them hours to answer it. It's not just once. It happens regularly. On 12/7/23 at 3:30 AM, V11, CNA stated I heard there was a CNA on third shift sleeping and not answering call lights, but I only heard. I didn't see it. She's not here anymore. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/7/23 at 5:23 AM, V1, Administrator, stated There was a CNA that was caught sleeping, but she was in her probationary period and was let go. I'll have you talk to (V14, Human Resources) when she comes in because she'll know more about it. It only happened the one time. On 12/7/23 at 8:30 AM, V14, Human Resources, stated (V15, CNA) was caught sleeping on third shift. She was new and still in her probationary period. We had a meeting set up to find out what happened, but she never showed up to the meeting or work. I never heard from her again. From what I understand, it was an isolated incident. On 12/7/23 from 9:00 AM to 9:35 AM, a continued observation of call lights was conducted. room [ROOM NUMBER]'s call light came on at 9:04 AM and was answered by staff at 9:25 AM. room [ROOM NUMBER]'s call light came on at 9:04 AM and was answered by staff at 9:28 AM. On 12/7/23 at 12:25 PM, V1, Administrator, stated I think 30 minutes is not timely. I would say 20 minutes is pushing it. You saw longer than normal wait times for the call lights because around 9:00 AM is one of our busiest times. On 12/7/23 at 12:30 PM, V2, Director of Nursing (DON) stated I would like the call lights to be answered no more than 20 minutes. If my loved one was in a nursing home, it would want them to wait any longer than that.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41869 Based on observation, interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for one resident (R8) out of three residents reviewed for abuse in a sample of eight. This failure resulted in R8 having feelings of being intimidated for prolonged periods of time. Findings include: The facility's Abuse policy dated 10/24/22 documents The administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. R8s minimum data set (MDS) documents a brief interview of mental status (BIMS) of 15. A BIMS of 12 -15 indicates a resident is cognitively intact with 15 being the highest score. On 12/7/23 at 9:35 AM, V6, Certified Nursing Assistant, observed entering R8's room. Upon entry of R8's room, R8 stated I want to get up. V6 replied in a stern tone I said 10:30. R8 stated But I want to get up now. V6 replied raising her voice You think you're above everyone else? It'll be 10:30 like I said! You want to play games? Then that's what we'll do we'll start playing games! At this point R8 started crying and stated, Every time you're my CNA, you do this to me. V6 replied in an even louder tone stating I'm down here working hard to be here (raising voice) on time (yelling) for you! While still crying R8 started talking and V6 interrupted her started stating that she was going to (V1, Administrator) to be taken off of R8's group. As R8 was still trying to speak, V6 started yelling I'm not going back and forth with you! I'm not going to let you disrespect me! At that point, while still crying, R8 pointed to this surveyor and stated, He's from the state and just heard everything you said. V6 turned looked at this surveyor and stated, I don't care. On 12/7/23 at 9:40 AM, V1 Administrator, was informed of the incident. V1 stated That's not how we do things here. (R8) can be a very difficult person to work with, but that's still no excuse. (V6, CNA) should have walked out of the room and taken a moment instead of arguing with (R8). On 12/7/23 at 9:55 AM, V1 Administrator, stated I went down to talk with (R8) about the situation, but she didn't say much. I think she's still upset about the situation. (V6, CNA) has taken off the floor and sent home. On 12/7/23 at 10:45 AM, R8 stated No I'm not OK. It's not the first time (V6, CNA) has yelled at me. (R8's voice started cracking and her eyes became watery) Every time (V6) works with me, she makes me feel belittled. Like I'm not good enough. She treats me as though she's the boss and has power over me. Every time she's here I feel intimidated. I feel this way the entire time (V6) is here. It's the whole shift until she goes home. I didn't tell anyone because it won't do any good.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41869 Based on interview and record review, the facility failed to provide showers to four residents (R1, R2, R4 and R5) out of five residents reviewed for showers in sample of eight. Findings include: The facility's Bath and Shower procedure undated documents The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition the resident's skin . Document procedure in the resident's electronic health record. The facility's AM shower schedule documents R1, R4 and R5 are to receive showers on Wednesday and Saturday and R2 on Tuesday and Friday. R1's medical record documents R1 was admitted to the facility on [DATE] and discharged on [DATE]. R1's medical record does not document a shower was completed during this time frame. On 12/7/23 at 11:00 AM, V1, Administrator, stated they do not have a completed shower sheet or documentation showing R1 received a shower during her stay. R2's medical record and shower sheets does not document R2 received a bed bath or shower from 11/3/23 until 11/23/23. R4's medical record and shower sheets does not document R4 received a bed bath or shower from 11/8/23 until 11/19/23. R5's medical record and shower sheets does not document R5 received a bed bath or shower from 11/8/23 until 11/18/23. On 12/6/23 at 7:50 AM, V7, Licensed Practical Nurse (LPN) stated With there only being three CNAs in the building, we do miss showers, but we try to make it up on Sunday. That doesn't always happen, but they try. If a resident refuses a shower, the resident has to sign a refusal and the nurse has to talk to them. That happens rarely though. Most residents grab their shower when they can because who knows when they'll get their next one. On 12/6/23 at 8:05 AM, V6, Certified Nursing Assistant (CNA), stated When you have three CNAs to 60 residents, sometimes showers don't get done. It happens a lot. On 12/6/23 at 8:10 AM, V8, CNA, stated We only have three CNAs today. When that happens, we aren't able to get all the showers completed so they get pushed to the next day and the next. We're always playing catchup. There are times when they just don't get done. On 12/6/23 at 8:15 AM, V9, CNA stated Only having three CNAs to 60 residents happens more than usual. As a result, not all the cares like showers get done. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/23 at 8:48 AM, R1 stated I wasn't getting my shower when I was there. I was there for about two and a half weeks and never got one. On 12/6/23 at 9:15 AM, R5 stated I'm supposed to get my showers on Wednesday and Saturday but I'm not getting them on time. Sometimes I have to wait until late in the afternoon and other times I just don't get one. On 12/6/23 at 9:30 AM, R2 stated I've been here a couple of weeks, and no one has offered to give me a shower. I got tired of waiting, so I asked for some towels and started cleaning myself in the sink. On 12/6/23 at 9:35 AM, R4 stated I wasn't getting my bed baths like I was supposed to. I had to go two weeks between baths.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41869 Based on observation, interview and record review, the facility failed to identify and provide the sufficient staffing necessary to meet the needs of the residents. This failure has the potential to affect all 60 residents residing in the facility. Findings include: The facility's Facility Assessment revised 2018, does not include staffing requirements necessary to meet the needs of the residents based on the resident population and census. The facility's Resident Council Minutes dated 9/25/23 documents Resident stated not enough CNAs (Certified Nursing Assistant). The facility's Resident Council Minutes dated 11/27/23 documents Department Concern: g. Nursing: Would like to see more CNA help. On 12/6/23 at 7:40 AM, V10, Registered Nurse (RN) stated We only have the three CNAs here right now for 60 residents. We normally run with four, but there are days we only have three. On 12/6/23 at 7:50 AM, V7, Licensed Practical Nurse (LPN) stated With there only being three CNAs in the building, we do miss showers, but we try to make it up on Sunday. That doesn't always happen, but they try. The residents have complained that things aren't getting done. We have a lot of two person assists on this side of the hall, so I jump in and spot. When you only have three CNAs to 60 residents, things aren't getting done. On 12/6/23 at 8:05 AM, V6, CNA, stated We only have three CNAs today with 60 residents. When you have three CNAs to 60 residents, sometimes showers don't get done. It happens a lot. I've heard the residents complain, but we try our best to prioritize what we have to do because there isn't enough of us to get everything done. On 12/6/23 at 8:10 AM, V8, CNA, stated We only have three CNAs today. When that happens, we aren't able to get all the showers completed so they get pushed to the next day and the next. We're always playing catchup. There are times when they just don't get done. On 12/6/23 at 8:15 AM, V9, CNA stated Only having three CNAs to 60 residents happens more than usual. As a result, not all the cares like showers get done. On 12/6/23 at 8:48 AM, R1 stated They don't have enough CNAs. I didn't get my shower because they said they didn't have enough staff. It would take the CNAs two hours to answer my call light. I got tired of waiting for my call light to be answered one night so I transferred myself to the wheelchair and went out in the hallway and found a CNA sleeping. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/6/23 at 9:15 AM, R5 stated When I asked them why I wasn't getting my shower or why it takes them so long to answer my call light, I always get the same answer. They're short of staff. Then hire some more! We shouldn't have to suffer because the company won't pay for more staffing. On 12/6/23 at 9:30 AM, R2 stated I've been here a couple of weeks, and no one has offered to give me a shower. I got tired of waiting, so I asked for some towels and started cleaning myself in the sink. I would like to get a shower, but I know they're short staffed, so I try not to bother them. On 12/6/23 at 9:35 AM, R4 stated The excuse they give me of why it takes them hours to answer my call light or why they didn't give me a bed bath is staffing. They don't have enough staff to meet everyone's needs. The DON (Director of Nursing) even had to pass medication one day because there weren't enough nurses. On 12/6/23 at 3:15 PM, V1, Administrator, stated I didn't know the Facility Assessment had to include what our staffing numbers had to be. Right now, I can't answer your questions on what our staffing ratios for our resident population should be. I'll have to talk to corporate and see if we can get the Facility Assessment updated for you. The facility's Daily Assignment Sheet dated 10/1/23 through 12/6/23 was reviewed. The daily assignment sheet dated 12/6/23 documents four CNAs on AM shift. On 12/7/23 at 8:40 AM, V2, Director of Nursing was given back the daily nursing schedule and asked why 12/6/23 documents four CNAs working on AM shift when there were only three CNAs working. V2 stated Oh, the nurses didn't write down the call off. V2, was given the daily nursing assignments and asked to correct them to show who was actually working and who wasn't. On 12/7/23 from 9:00 AM to 9:35 AM, a continued observation of call lights was conducted. room [ROOM NUMBER]'s call light came on at 9:04 AM and was answered by staff at 9:25 AM. room [ROOM NUMBER]'s call light came on at 9:04 AM and was answered by staff at 9:28 AM. On 12/7/23 at 12:25 PM, V1, Administrator, stated You saw longer than normal wait times for the call lights because around 9:00 AM is one of our busiest times. On 12/7/23 at 1:08 PM, V1, Administrator, stated I was told we won't have the updated Facility Assessment for you. Corporate said they need to do a re-assessment to see what our staffing numbers need to be for our resident population. As far as the daily staffing sheets go, not all of them are accurate. The nurses were not adding the call offs. I tried to print the payroll report, but it's not going to show you what you need. I don't know what to tell you at this point. The facility's census report dated 12/6/23 and verified by V1, Administrator, documents 60 residents residing in the facility.

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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. 41869 Based on observation, interview and record review, the facility failed to prevent cross contamination of food products during meal service. This failure has the potential to affect all 60 residents residing in the facility. Findings include: The facility's Proper Hand Washing and Glove Use policy dated 2020 documents 7. Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for break, or to another location in the building; after handling potentially hazardous raw food; or if the gloves become contaminated by touching the face, hair, uniform or other non-food contact surfaces such as door handles and equipment. On 12/7/23 at 7:15 AM, V4, Food Service Director (FSD), observed standing at the steam table preparing meal trays for breakfast meal. V4 picked up sausage and toast with her gloved hand and placed it on a plate, handed it to another kitchen staff worker who placed it in a food warmer. V4 then walked around the steam table to the kitchen entry, grabbed the door handle, opened the door, and assisted another staff member push the food warmer out the door. V4 then grabbed another food warmer, pushed it to the corner of the steam table, walked back around the steam table and proceeding grabbing toast and sausage with the same gloved hand and prepared more resident trays. V4 did not change her gloves or perform hand hygiene during the entire observation. On 12/7/23 at 7;26 AM, V4, FSD, verified she did not change her gloves and stated We should be changing our gloves before serving food if we've been touching other items in the kitchen. I now realize what I was doing. I grabbed the food warmer and door handle and then grabbed the sausage and toast with the same gloves. Sometimes we get caught up in a routine and forget to change gloves. The facility's census report dated 12/6/23 documents 60 residents residing in the facility. V5, MDS (Minimum Data Set) coordinator, verified all 60 residents eat the meals served by the facility.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 41869 Based on interview and record review the facility failed to complete their facility assessment to include the staffing requirements needed to care for the resident population and census. The facility also failed to review the facility assessments annually. This failure has the potential to affect all 60 residents residing in the facility. Findings include: The facility's Facility Assessment revised 2018, does not include staffing requirements necessary to meet the needs of the residents based on the resident population and census. On 12/6/23 at 3:15 PM, V1, Administrator, verified the Facility Assessment was last reviewed in 2018 and stated I wasn't aware the Facility Assessment needed to be reviewed every year. I didn't know it had to include what our staffing numbers had to be. Right now, I can't answer your questions on what our staffing ratios for our resident population should be. I'll have to talk to corporate and see if we can get the Facility Assessment updated. On 12/7/23 at 1:08 PM, V1, Administrator, stated I was told we won't have the updated Facility Assessment for you. Corporate said they need to do a re-assessment to see what our staffing numbers need to be for our resident population. The facility's census report dated 12/6/23 and verified by V1, Administrator, documents 60 residents residing in the facility.