STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145930	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Pontiac Nursing Home	1225 South Ewing Drive Pontiac, IL 61764

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35046 Based on observation, interview and record review the facility failed to ensure that residents are treated with respect and dignity. This failure affects three (R76, R43, & R66) of twenty four residents reviewed for dignity on the sample list of 30. Findings include: The facility's Dignity policy dated 11/28/12 documents, The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This policy also documents that maintaining a resident's dignity should include refraining from practices demeaning to residents. 1. On 5/14/24 at 10:42 AM, R76 stated that V25 Certified Nurse's Assistant asked her if she had pooped right in the hallway in front of everyone. R76 stated she felt embarrassed by V25 asking her this out in the hallway. R76 stated she told V26 Licensed Practical Nurse about it. On 5/15/24 at 11:38 AM, V26 stated that R76 did report to her that V25 asked her if R76 pooped in the hallway. V26 stated it is not appropriate to ask that in the hallway and that she should have asked her in the room. 34201 2. R43's MDS (Minimum Data Set) dated 2/28/24 documents R43 has severe cognitive impairment. On 5/13/24 at 12:35 PM, R43 was sitting in the lounge area eating lunch, by R43's self, away from all other residents who were in the dining area. At this time, V3 ADON (Assistant Director of Nursing) / Licensed Practical Nurse stated V3 is unsure why R43 is in the lounge area by R43's self other than the fact that R43 likes to tool around and take food off of other resident trays. R43's Care Plan dated 4/23/24 does not document that R43 takes food from other residents and is to sit by R43's self. 49492 (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 - Few	3. 05/13/24 11:55 AM R66 Urinary drainage bag observed hanging on the right side of the bed at the foot of the bed, visible from doorway/hallway. No dignity/cover bag observed. 05/13/24 1:15PM R66 Record review indicate a diagnosis of Neuromuscular Dysfunction Of Bladder indicating the need of an indwelling urinary catheter to drain the bladder. 05/14/24 09:00 AM R66 Urinary drainage bag hanging on the foot of the bed at the right side, uncovered/not placed in dignity bag at this time visible from the doorway/hallway. 05/14/24 09:05 AM R66 states staff just hang the bag from the bed and leave. R66 states he has had the indwelling urinary catheter for a long time due to not being able to empty his bladder on his own. R66 states a doctor told R66 has sign and symptoms of Multiple Sclerosis and will always have the need for a catheter going forward. 05/16/2024 09:18 AM V2 and V3 both state that all nursing staff should be putting all urinary collection/drainage bags inside a dignity bag unless being drained to protect resident dignity and privacy.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 49492 Based on observations, record reviews, resident and staff interviews, the facility failed to complete a self-administration of medication assessment for one of one resident (R29), reviewed for self-administration of medication. Findings Include: 05/15/24 09:15 AM R29 was observed with a medication cup on the bedside table with several unidentified medications still inside. R29 was observed with eyes closed resting in a recliner at this time. 05/15/24 09:20 AM R29 room door under constant observation from 09:15 AM until V12 (Registered Nurse) returned to nurses station at 09:20 AM. V12 then accompanied this surveyor to R29's room. V12 looked at the medication cup located on bedside table and picked it up from the bedside table concealing it in her left hand. V12 then aroused R29 by shaking R29's right hand/speaking loudly over the television and asked R29 why R29 did not take his medication. V12 was asked if V12 left the medication cup containing the medications at the bedside, V12 stated V12 left a calcium tablet at the bedside but did not leave this medication cup with medications in it. 05/15/24 09:25 AM V2 (Director of Nursing) stated nurses are not supposed to leave medications at the bedside, the nurse is supposed to watch the residents take the medications. 05/15/24 09:30 AM Clinical Physician Orders record review does not contain a physician order for medication self-administration. 05/15/24 09:40 AM R29 Standard Assessments record review does not contain an assessment for medication self-administration. 05/15/24 09:45 AM R29 Care Plan review indicate to Administer medications as ordered and to monitor/document for side effects and effectiveness by the License Practical Nurse (LPN), or Registered Nurse (RN).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34201 Based on interview and record review, the facility staff failed to report allegations of abuse to the Abuse Coordinator for one of three residents (R44) reviewed for abuse on the sample list of 30. Findings Include: R44's MDS (Minimum Data Set) dated 3/14/24 documents R44 has severe cognitive impairments. R44's Nursing Progress Notes document the following: 5/11/24 at 3:34 am by V27 RN (Registered Nurse) - R44 expresses frustration toward staff members, refusing care, and accusing CNAs (Certified Nursing Assistant's) of punching R44 in the gut. Upon inspection, R44 had no bruising or redness to indicate a punch to the gut. 4/27/24 by V28 LPN (Licensed Practical Nurse) - R44 was sitting out in the living room on the wing. There was another resident (unidentified) talking to a stuffed animal. R44 started yelling at that resident, Shut up . you need to comb your hair .When staff told resident that we don't talk like that, R44 said F*** you b****. When staff educated R44 that if R44 was going to talk like that, R44 could go to R44's room because that isn't nice to talk to people that way, R44 then stated to the other resident, stop yelling or I'll hit you in the head. Staff kept R44 away from other residents as R44 walked R44's self back to her room. R44 was raising R44's middle finger and saying f*** you to the staff. On 5/13/24 at 1:27 PM, V1 Administrator stated V1 has not had any allegations of abuse reported to V1. On 5/15/24 at 1:08 PM, V1 stated V1 was not aware of the above allegations as nobody reported them to V1. V1 explained staff have all been inserviced many times therefore should be aware of what needs reported and explained, this should have been reported. On 5/15/24 at 2:09 PM, V28 stated on 4/27/24 R44 was lashing out, yelling and threatening to hit another resident (unidentified) . V28 stated, sometimes R44 just gets up in a bad mood and lashes out and takes it out on others but then at other times, R44 is as sweet as pie. V28 stated V28 has been instructed on what constitutes as abuse and what needs reported and explained V28 thinks that R44 was just angry. V28 stated R44 went back to R44's room when instructed to do so, if (R44) kept doing it {yelling and threatening}, I (V28) would have reported it. On 5/16/24 at 4:22 PM, V2 DON (Director of Nursing) with V1 present stated that V2 counseled V27 that R44's allegations that R44 was hit in the stomach should have been reported to V1 immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Abuse Prevention and Reporting Policy dated 4/14/22 documents abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse includes verbal, sexual, physical and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must them immediately report it to the administrator.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Based on interview and record review, the facility failed to accurately code the Minimum Data Set for three of 24 residents (R29, R43, R53) reviewed for Assessments on the sample list of 30. Findings Include: 1) R43's MDS (Minimum Data Set) dated 2/28/24 documents R43 has limited ROM (Range of Motion) to both bilateral upper and lower extremities. R43's Care Plan dated 4/23/24 does not document any limited ROM. On 5/13/24 at 1:57 PM, V3 ADON (Assistant Director of Nursing) / LPN (Licensed Practical Nurse) stated R43 does not have any limited ROM. On 5/14/24 at 3:05 PM, V5 LPN stated R43 has full ROM to all extremities but does have some weakness in the legs. On 5/15/24 at 10:45 AM, V29 MDS Coordinator stated R43's MDS was completed prior to V29 starting at the facility so V29 is not sure why it is coded the way it is but verified that it is coded incorrectly as R43 does not have any limited ROM. 2) R53's May 2024 Physician Orders documents an order dated 3/25/24 to admit into hospice care for comfort measures only. R53's Care Plan dated 3/25/24 documents R53 is on hospice. R53's MDS (Minimum Data Set) dated 3/29/24 does not document that R53 is receiving hospice care. On 5/14/24 at 11:18 AM, R53 confirmed R53 was placed on Hospice after having a small stroke but has improved so will be coming off of hospice. On 5/15/24 at 11:23 AM, V29 MDS Coordinator confirmed R53's MDS is coded incorrectly due to not having hospice care marked and stated it should have been. 49492 3) 05/13/2024 09:50 AM V1 states there are no residents currently receiving dialysis in the facility. 05/15/24 09:20 AM V12 (Registered Nurse) stated R29 has a left forearm fistula (Dialysis access port) but R29 has never had dialysis. R29 states R29 has not had dialysis and does not want dialysis at this time. 05/15/24 09:25 AM V2 (Director of Nursing) and V3 (Assistant Director of Nursing) review Minimum Data Set (MDS) for R29. R29 MDS Section O dated Tue [DATE] at 09:19:21 AM is marked (documented) Yes, R29 as having dialysis while a resident. V2 and V3 agree that R29 has never had dialysis while a resident in this facility and the MDS was completed incorrectly. V2 states R29 had the left arm fistula placed in January 2024 but has not had dialysis performed. V2 states the left arm fistula has never been accessed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 35046 Based on observation, interview, and record review the facility failed to assist with shaving and nail care for two (R12, R69) of twenty four residents reviewed for activities of daily living on the sample list of 30. Findings include: 1. R12's care plan dated 12/18/23 documents that R12 has a self care performance deficit. This documents that R12 needs supervision with touch assistance for personal hygiene. This care plan also documents an intervention for staff to check nail length and to clean nails as needed. On 5/14/24 at 10:30 AM, R12 was sitting in the hallway in a wheel chair. R12's face was partially shaved. R12's neck and cheeks had an over growth and sides of face. R12 stated that he shaved himself and that he did the best he could. R12's fingernails were jagged and had an accumulation of a black substance underneath them. On 5/15/24 at 11:36 AM, R12 was sitting in the hallway. The sides of his face and neck continued to have an overgrowth of facial hair. R12 stated he did the best he could to shave his face. R12 stated he likes to be clean shaven but needs help and can't do it by himself. R12 fingernails remained jagged and continued to have an accumulation of a black substance underneath them. On 5/16/24 at 2:00 PM, V1 Administrator stated that R12 does require assistance with shaving and the staff should help him. 2. R69's care plan dated 4/19/23 documents R12 has a self care performance deficit related to weakness. This care plan documents R12 requires extensive assistance of one staff member for assistance with personal hygiene. On 5/13/24 at 12:20 PM, R69 was sitting at the dining room table. R69 had one quarter inch growth of facial hair. When asked if growing a beard, rubbed face and stated no, just waiting for someone to cut it or me, anybody will do, what are you doing now, can you do it?

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Based on observation, interview and record review, the facility failed to ensure a pressure ulcer wound treatments was completed as ordered, implement pressure relieving interventions and prevent potential cross contamination of the wound for two of five residents (R13, R51) reviewed for pressure ulcers on the sample list of 30. Findings Include: The facility's Pressure Ulcer Prevention Policy dated 1/15/18 documents specialty mattresses such as a low air loss, alternating pressure, etc mattress may be used as determined clinically appropriate. Specialty mattresses are typically used for resident who have multiple stage 2 wounds or one or more stage 3 or stage 4 wounds, and use a pressure reducing pad in chairs of all types to protect bony prominence's for residents. 1) On 5/13/24 at 11:29 AM, V3 LPN (Licensed Practical Nurse)/ADON (Assistant Director of Nursing) stated that R51 has a chronic stage four Pressure Ulcer to the Sacrum. On 5/13/24 at 11:36 AM, R51 was sitting up in a wheelchair with a gel pressure cushion seat at the dining room table. R51 had a mechanical lift sling under R51 and between R51's buttocks and the gel pressure cushion. On 5/14/24 at 8:25 AM, R51 was sitting up in a wheelchair with a gel pressure cushion seat but also had a mechanical lift sling between R51's buttocks and the gel pressure cushion. At this time, R51's bed had a regular mattress on it. R51's Wound assessment dated [DATE] documents R51 has a stage four pressure ulcer to the sacrum measuring 0.3 cm (centimeters) by 0.5 cm by 0.9 cm. R51's May 2024 Physician Orders document the following order to the Coccyx wound - cleanse with wound cleanser pack with indoor gel to wound bed place small piece of calcium alginate with silver over the top of the wound bed then cover with a thick absorbent pad and secure in place daily. If iodoform gel is not available, may use honey. R51's Care Plan dated 5/8/24 documents R51 has a pressure ulcer to the sacrum with interventions that include: educate family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor nutritional status and serve diet as ordered, monitor intake and record, monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, signs of infection, assist with repositioning approximately every two hours, pressure relieving/reducing mattress on bed and pad in chair, encourage/assist to use the bathroom every two hours and PRN in an attempt to reduce incontinent episodes, complete treatment as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 10:19 AM, V2 DON (Director of Nursing) and V8 CNA (Certified Nursing Assistant) donned gowns and entered R51's room to provide wound care. At this time, V2 DON stated R51 is on EBP (Enhanced Barrier Precautions) due to having a pressure wound. Both V2 and V8 washed hands and donned gloves. R51 was lying in bed on a regular mattress. V8 rolled R51 to left side and V2 removed R51's wound dressing to the sacrum which consisted of a small piece of thick absorbent dressing that had a small amount of yellow drainage on it. No calcium alginate was on the wound as ordered. The wound to the sacrum presented as a stage four pressure ulcer. V2 measured the wound and reported the measurements as 0.6 cm by 0.4 cm by 1.1 cm. After cleansing the wound appropriately, V2 applied the iodoform gel to the wound base, then pulled a pair of scissors out of V2's uniform pocket to cut the silver calcium alginate and thick absorbent pad, before placing them over the wound. V2 confirmed V2 used scissors from V2's pocket and did not clean them prior to using them and stated, V2 had already cleansed the scissors with bleach wipes prior to placing them in (V2's) pocket. At this time, V2 also confirmed the dressing that V2 removed from R51 did not contain the ordered silver calcium alginate. V2 also confirmed that R51 was on a regular mattress and should be on an alternating pressure air mattress and explained that is V2's fault because V2 thought R51 was already on one. On 5/14/24 at 1:34 PM, R51 was sitting up in the wheelchair with the mechanical lift sling under R51 and between R51's buttocks and pressure relieving cushion. On 5/14/24 at 1:53 PM, V5 LPN stated R51 has had the same wound the entire time and even though it is sometimes documented as the coccyx and other times as sacrum, it is the same wound. On 5/15/24 at 4:20 PM, V2 confirmed that sitting on a transfer sling could interfere with pressure relieving interventions when up in the wheelchair. 42702 2.) R13's care plan dated 5/23/24 documents a risk for pressure ulcer development due to weight, mobility, bowel incontinence, and fragile skin. R13's Minimum Data Set, dated dated dated [DATE] documents R13 is cognitively intact. R13's care plan dated 5/2/24 documents that R13 is dependent on two staff, requiring the mechanical lift, for toileting needs including catheter care and incontinence care. R13's care plan dated 5/6/24 documents to report any changes in skin status. R13's bowel and bladder record dated 5/11/24, 5/14/24 and 5/15/24 documents bowel movements on these dates. On 5/14/24, R13's medical record does not document any current wounds or wound treatment. On 5/14/24 at 10:41 AM, R13 said that she has wounds that come and go on her buttocks and legs and that she feels like there is one there now and has been for several days. On 5/15/24 at 12:00 PM, V2 Director Of Nursing assisted R13 to roll onto left her left side to complete pericare. An open stage two pressure ulcer the size of a quarter was on R13's right buttock. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 12:30 PM, V17 Certified Nursing Assistant (CNA) stated that she provided pericare/catheter care to R13 this morning and that R13 had an open wound, but that they wiped barrier cream over it and didn't tell anyone. On 5/15/24 at 1:56 PM, V2 said that based on how the wound looks, she would guess that it had been open for a few days and that the CNA's should have reported it.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 34201 Based on observation, interview and record review, the facility failed to provide behavioral health services to maintain the highest practicable mental well-being for a resident diagnosed with major depression. This failure affects one of two residents (R53) reviewed for behavioral health services on the sample list of 30. This failure resulted in R53 being tearful, visibly shaking, and expressing despair. Findings Include: R53's ongoing diagnosis listing documents the following diagnoses: Vascular Dementia without Behaviors, Anxiety Disorder and Major Depression. R53's May 2024 Physician Order Sheets documents an order for Lorazepam {Benzodiazepine} topical gel 1 mg (milligram) per ml (milliliter) to the inner wrist or other hairless area prn (as needed) every every 4-6 hours for anxiety or agitation but does not have any medication orders for R53's diagnosis of major depression. On 5/14/24 at 11:21 AM, R53 was sitting up in a wheelchair in the doorway of R53's room. R53 became tearful and began to shake when talking about having to come to the long term care facility. R53 stated R53's family told R53 that R53 was not taking care of R53's self or dog, so they initially put R53 into an assisted living facility and now R53 is in long term care. R53, while still crying, explained R53's family sold everything that R53 owned stating, I have nothing now. R53 stated, they tell me (R53) I'm adjusting but I don't feel I am adjusting, I just want to run away and keep running and running with no place to go. R53's Care Plan dated 3/25/24 documents R53 has a psychosocial well-being problem related to R53's medical diagnosis of Anxiety Disorder and Major Depressive Disorder with interventions that include: allow R53 time to answer questions and to verbalize feelings perceptions, and fears as needed; Assist/encourage R53 to set realistic goals; Encourage participation from R53; Increase communication between R53/family/caregivers about care and living environment; and explain all procedures and Treatments, Medications, Results of labs/tests, Condition, All changes, Rules, and options. This Care Plan also documents R53 is on hospice and will work cooperatively with the hospice team to ensure R53's spiritual, emotional, intellectual, physical and social needs are met. R53's medical record does not contain any documentation that R53 is obtaining any behavioral health services to assist R53 in coping with R53's depression. On 5/15/24 at 10:30 am, V10 SSD (Social Service Director) stated any resident who takes any type of psychotropic medication is referred to behavioral health services upon admission, or when started on medication however R53 was not do to being on hospice and hospice wanting to manage their own medication. At this time, V10 explained that when R53 was admitted to the facility, R53 was unresponsive and non-verbal however R53 has improved so much, R53 is being taken off of hospice. V10 was not aware of R53 being severely emotionally about being at the facility and R53's recent events. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 5/15/24 at 11:00 am, V10 stated V10 completed a PHQ (Patient Health Questionnaire) - 9 on R53 and stated R53 scored a 12, which indicates possible depression. V10 stated that V10 called V32 (R53's POA (Power of Attorney)) after completing the assessment to see if it was okay for R53 to be seen by behavioral health services and V32 gave permission and actually stated that R53 had been taking an antidepressant for depression prior to being placed on hospice. The facility's Hospice Service Agreement dated 11/3/23 documents the facility will furnish to the individual who is both a resident of Facility and a patient of Hospice, all of those services which Facility normally would have provided in the absence of Hospice Program, as provided for the Facility's policies, procedures, and protocols as required by State and Federal Law and agreements with the resident and the resident's family.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145930	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Pontiac Nursing Home	1225 South Ewing Drive Pontiac, IL 61764

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34201 Based on interview and record review, the facility failed to ensure that as needed psychotropic medications were limited to 14 days or less for one of five residents (R53) reviewed for psychotropic medications on the sample list of 30. Findings Include: R53's May 2024 Physician Orders document an order dated 4/5/24 for Lorazepam {benzodiazepine} topical gel 1 mg (milligram) per ml (milliliter) - apply 1 ml to the inner wrist or other hairless area every 4-6 hours PRN (as needed) for anxiety or agitation. The facility's Psychotropic Medication-Gradual Dosage Reduction Policy dated 2/1/18 documents PRN hypnotic, antianxiety or antidepressant medications shall not be used beyond 14 days unless the prescribing practitioner indicates the clinical rationale for extended use and the expected duration for PRN use of the medication. On 5/15/24 at 10:25 am, V2 DON (Director of Nursing) stated PRN psychotropic medications, including Lorazepam, should be limited to 14 days or less.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34201 Based on observation, interview and record review, the facility failed to administer medications according to Physician Orders and follow Manufacturer's Recommendations for medication administration for two of six residents (R36, R71) reviewed for medication administration on the sample list of 30 . The facility had two errors out of 34 opportunities for a medication error rate of 5.88%. Findings Include: 1. On 5/14/24 at 3:23 pm, V30 RN (Registered Nurse) entered R36's room to check R36's blood glucose level, which was 156. At this time, V30 stated V30 was only checking R36's blood glucose level and would be giving R36 the ordered insulin, which will be 5 units per the sliding scale orders and other ordered medications at 4:00 pm. R36's May 2024 Physician Order Sheet documents orders to check R36's blood glucose levels TID (three times a day) and is set up for 6:00 am, 12:00 pm and 4:00 pm. These orders also document to administer Lispro Insulin Subcutaneous Solution Pen Injector 100 U (Units) per ml (milliliter) per sliding scale: if 0 - 130 = 0 u; 131 - 200 = 5 u; 201 - 250 = 10 u; 251 - 300 = 15 u; 301 - 350 = 20 u; 351 - 400 = 30 u; 401 - 450 = 40 u; 451 - 500 = 50 u; 501 - 550 = 60 u; 551 - 600 = 70 u subcutaneous three times a day which is scheduled for 8:00 am, 12:00 pm and 5:00 pm. On 5/14/24 at 4:15 pm, V30 prepared and administered all of R36's medications ordered for 5:00 pm which included the 5 units of sliding scale Lispro Insulin {Fast Acting Insulin}. The label documents to administer per sliding scale coverage with meals. At this time, R36 was lying in bed, without food and V30 did not offer any food to R36. On 5/14/24 at 4:45 pm, 30 minutes after administration of Lispro, R36 still did not have any food served to R36. The Instructions for Use for Lispro dated 2023 documents that Lispro is a fast acting insulin that should be administered 5-15 minutes prior to a meal. 2. On 5/14/24 at 3:35 pm, V30 RN entered R71's room to check R71's blood glucose level, which was 154. V30 stated R71 will receive 2 units of insulin and will return around 4:00 pm to administer it. R71's May 2024 Physician Orders document to administer Novolog R Solution 100 U (units) per ml (milliliter) per sliding scale of: if 150 - 200 = 2 u; 201 - 300 = 4 u; 301 - 999 = 6 u subcutaneously with meals for diabetes. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 4:05 PM, R71 was lying in bed without food. V30 prepared and administered R71's ordered 2 units of Novolog insulin and did not offer R71 anything to eat. On 5/14/24 at 4:45 pm, 40 minutes after receiving insulin, R71 still did not have supper. On 5/14/24 at 4:45 pm, V31 Dietary Manager confirmed R36 and R71 have not been served dinner yet as the first hall cart to the opposite wing was just being served and explained the other wings will be served after that, then the main dining room will be served. The facility's undated Medication Administration General Guidelines document medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of the prescriber.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50322 Based on observation, interview and record review, the facility failed to ensure residents are free of significant medication errors, by administering a residents intravenous antibiotic medications without consulting the physician due to critical lab values. This failure affects one (R71) resident out of a sample of 30. Findings include: The facility's Infusion Therapy Procedures policy dated 12/2014 documents: Anti-Infective Therapy lists policy to provide for safe and effective administration of anti-infective therapy. Procedures include the patient will be assessed by the nurse and physician prior to medication administration to ensure that the patient is clinically stable and has no previous history with adverse medication including lab work monitoring. R71's physician order summary documents order for Ceftriaxone 2 grams intravenously every 24 hours at 2:00 PM and Vancomycin 1500 milligrams intravenously every 24 hours for a foot infection. This physician order summary documents a lab orders dated 5/8/24 to obtain a vancomycin trough level every week prior to infusion of antibiotic. R71's laboratory results dated [DATE] documents a vancomycin trough level of 43. This report documents that this is a critical high level. On 5/15/24 at 7:35 AM, V9 Registered Nurse administered Vancomycin 1500 milligrams intravenously to R71. On 5/15/24 at 9:45 AM, V9 stated R71 had a vancomycin trough this morning and the lab called with critical results. V9 states she called the physician's office and left a message but did not speak with anyone. V9 states she did administer today's dose because there was no order to hold the Vancomycin if the lab trough was high. At this time, the bag of Vancomycin attached to R71's intravenous site was empty. On 5/15/24 at 10:45 AM, V13 Pharmacist states that R71 should not have received the dose today based on trough level, could develop Red Man Syndrome(redness to face, neck, torso), and could impair kidney function. V13 states she sent an order dated 5/15/24 at 10:43 AM to hold vancomycin and draw a trough level daily until R71's trough level was below 20. R71's Creatinine with Glomerular Filtration Rate (kidney function test) results data dated 5/16/24 documents R71 has a glomerular filtration rate of 46 which is flagged as low and a blood creatinine level of 1.22 milligrams per deciliter. R71's physician orders dated 5/16/24 documents order to push fluids due to a diagnosis of acute kidney injury.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49492 Based on interview and record review, the facility failed to operationalize their Infection Prevention and Control Program by failing to track infections and conduct infection surveillance. These failures affects one resident (R13) and has the potential to affect all 80 residents residing at the facility. Findings Include: 1. The facility Infection Surveillance, Tracking and QA (Quality Assurance) Reporting Policy dated 2/14/18 documents the facility will identify, monitor, track and report infections and monitor adherence to infection control practices. Infection surveillance for compliance may include but is not limited to: review of laboratory/microbiology reports and results, observing for trends and monitoring to ensure appropriate precautions were initiated as appropriate. Infection Tracking includes but is not limited to: completing Infection Tracking Log for all residents with an infection and/or treated with antibiotics, track physician antibiotic prescribing practices as appropriate, monitor for trends by unit/location, clusters of same infection types/organisms, outbreaks, and employee illnesses. On 5/15/24 at 1:00 PM, V24 (Infection Preventist) provided the Infection Control/resident list documentation that does not include trending and infection surveillance, outbreak investigation and surveillance also remain incomplete with missing data entries for type/location of infection, infectious organism, and if isolation was required or not. The facility resident list report dated 5/14/24 lists 80 residents residing at the facility. 42702 2.) R13's physician orders dated 5/13/24 document that R13 is to be in strict contact and droplet isolation for Norovirus. R13's progross notes dated 5/14/24 at 1:14 AM documents strict isolation for Norovirus. On 5/13/24 at 12:30 PM, only a sign for enhanced barrier precautions was on R13's door. On 5/14/24 at 9:30 AM, only a sign for enhanced barrier precautions was on R13's door. R13's Minimum Data Set, dated dated dated [DATE] document R13 as cognitively intact. On 5/14/24 at 9:32 AM, R13 stated, I'm not on any isolation that I'm aware of. I went out to my restaurant yesterday to make the pies. The girls don't wear any gowns when they come in here. Last night I wasn't feeling good and I threw up. On 5/15/24 at 9:30 AM, R13's door signage included a sign for contact isolation and to see the nurse before entering. On 5/15/24 at 11:50 AM, V3 Assistant Director of Nursing said that R13 should have been on contact isolation as of 5/13/24. On 5/15/24 at 11:30 AM, V24 Infection Preventionist stated that she was doing education with staff regarding how they should handle isolation in the future.