STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145980	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of St Charles, The	850 Dunham Rd St Charles, IL 60174

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on interview and record review, the facility failed to ensure physician's orders for advanced directive information regarding the resident's choice for life-sustaining medical treatment was obtained and the information was readily available in case of an emergency for 1 of 1 resident (R22) reviewed for advanced directives in the sample of 26. The findings include: R22's Admission Record, printed by the facility on [DATE], showed he was admitted to the facility on [DATE]. On [DATE] at 9:16 AM, a review of R22's electronic medical record showed no order for R22's advanced directive information. R22's banner page (where this information can usually be found in a resident's electronic medical record), did not have any information regarding advanced directives for R22. The miscellaneous tab in R22's electronic medical record did not have any POLST (Practitioner Order of Life-Sustaining Treatment) document. On [DATE] at 3:37 PM, V3 (Licensed Practical Nurse/Restorative Nurse) said if a resident was in cardiac arrest, she would look in the POLST binder (located at the nurse's station) or in the resident's electronic medical record on the banner page to see what the resident's choice for life-sustaining treatment was. V3 said if she could not find the information there, she would check the resident's physician's orders to see what their advanced directives were. This surveyor requested V3 check R22's advanced directives. V3 verified that there were no directives in the POLST binder, R22's banner page or in R22'sphysician's orders. V3 said she could also check the miscellaneous tab for the POLST form. V3 checked and said there was no POLST form in the miscellaneous section in R22's electronic medical record. V3 said if a resident does not have any orders and no POLST form, CPR would be initiated. V3 looked in R22's hospital documents that were provided to the facility upon admission to the facility and said the documents provided by the hospital showed R22 was a DNR (do not resuscitate). V3 said it is important to make sure the resident's advanced directives are documented and orders are in place so we can properly treat the resident and honor their choice for life-sustaining treatment. R22's face sheet, physician's orders, and documents from admission from the local hospital were requested from V2 (Director of Nursing). On [DATE], R22's documents that were requested on [DATE] were provided. R22's Admission Record (face sheet) and physician's orders listed R22 as a full code. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:16 AM, V3 was questioned as to why R22 was listed as a full code now when the hospital documents showed he was a DNR. V3 said she spoke with R22's wife (V27) and V27 said it was okay to have R22 as a full code at this time, until she can get to the facility to sign the POLST form for DNR, because he (R22) wanted to be a DNR. V3 said they (the facility) could do a verbal consent over the phone, but (V27) is not able to come in and sign it because she cannot come to facility without her caregiver assistance and needs to find out when her caregiver is available. V3 said she spoke to V28 (Nurse Practitioner), and she said she will come in and sign the DNR today. On [DATE] at 11:44 AM, V2 (Director of Nursing) said the residents' advanced directives for life-saving medical treatment should be obtained on admission to the facility. V2 said it is important because if something happens, like the resident goes into cardiac arrest, the nurse knows how to proceed to honor the resident's wishes. The facility's [DATE] policy and procedure titled Advanced Directives and DNR Policy showed When a resident is admitted to the facility, a discussion of advance directives may take place between the resident or family, if the resident is incompetent, and the facility staff. This enables the staff to readily and clearly ascertain how to treat the resident in advance. The policy showed Under state and federal law, people have the right to make decisions regarding health care treatment. This includes their right to determine in advance what life-sustaining treatment will be provided, if any, in the future if they are unable to communicate those desires themselves. However, a resident is not required to complete a POLST (Practitioner Order of Life-Sustaining Treatment) upon admission .Individuals have the right to provide written instructions to their attending practitioner and family about their desire for treatments in in the future including life-sustaining treatment .It is the policy of this facility to follow an individual's physician order made in accordance with state law regarding advance directives limiting life-sustaining treatment. Advance directives will be placed in the electronic medical record along with the signed POLST or IDPH Uniform Do Not Resuscitate (DNR) Order Form. There will also be a DNR order placed in the POS (Physician's Order Sheet) section of the electronic medical record. The facility will also have a way to notify all staff of a resident's code status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on observation, interview and record review the facility failed to provide feeding assistance to a resident and failed to provide two showers per week as requested by a resident. This applies to two of three residents (R237 and R65) reviewed for activities of daily living in the sample of 26. The findings include: 1. The facility face sheet for R237 shows an admitted [DATE] and diagnoses to include vascular dementia, severe protein-calorie malnutrition, and dysphagia. The functional abilities and goals assessment completed on admission shows R237 requires partial to moderate assistance with eating. On 3/12/24 at 9:30 AM, R237 was observed sitting in her bed with her breakfast tray in front of her not attempting to eat anything. On 3/13/24 at 10:44 AM, R237 was in bed with her breakfast tray in front of her. Approximately 15% of the meal was gone. R237 said if she could get the food to her mouth, she would eat more because she was still hungry. That same day, R237 was observed in the lounge at 12:42 PM. A staff member was observed passing the lunch meal trays to the residents in their rooms. R237's lunch tray was in her room untouched. At 12:57 PM, R237 continued to sit in the lounge while several staff were observed walking past her and not offering to help her get to her meal. At 1:02 PM, a staff member got R237 and pushed her to the front exit and out the door for an appointment. At 3:06 PM, R237 was returned to the building and placed at the nursing station. R237 said she was hungry, and another resident gave her a cookie and a glass of water. At 3:16 PM, V7 (Scheduler) noticed R237 was back at the facility and told R237 she would get her a sandwich from the kitchen. On 3/13/24 at 3:30 PM, V7 said R237 was gone during lunch, and she would get her something to eat. On 3/14/24 at 9:00 AM, R237 was in bed attempting to eat her breakfast. Her eggs were on her abdomen, and she was looking for her spoon to eat her oatmeal. R237's spoon was also on her abdomen. R237 said she needed help with her coffee and oatmeal. This surveyor went into the hall to ask the staff to help her, and V6 (Certified Nursing Assistant/CNA) said there were two residents on the unit that needed feeding assistance and she was busy with the other resident. V6 said she would go help R237 as soon as she could. On 3/14/24 at 10:15 AM, V2 (Director of Nursing/DON) said any resident that requires feeding assistance needs to get the help they need. V2 said the facility has a dining area where residents who need feeding assistance can get the help they need and R237 should sitting in there. The speech pathology daily note dated 3/5/24 shows R237 requires continued feeding assistance. The mini nutritional assessment dated [DATE] shows R237 is at risk for malnutrition. The Physician orders for R237 dated 3/11/24 shows an order for a mechanical soft texture diet with one-to-one supervision. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy with a review date of 12/2023 for meal service shows all residents able to receive oral feeding at positioned, served, and encouraged to eat their meals. 11. residents are encouraged to eat by all facility staff. If a resident needs to be fed, they are fed. 34491 2. R65's Admission Record, provided by the facility on 3/14/24, showed he was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease with acute exacerbation, MRSA (Methicillin-Resistant Staphylococcus Aureus), Covid-19, moderate persistent asthma, type II diabetes mellitus, a tracheostomy, abnormalities of gait and mobility, and the need for assistance with personal care. R65's most recent comprehensive facility assessment dated [DATE], showed he was cognitively intact and required substantial to maximal assistance from staff for showering and bathing. R65's ADL (activities of daily living) care plan, dated 12/30/2023, showed he has an ADL self-care performance deficit. R65's care plan initiated on 1/23/2024 showed he is at risk for falls related to impaired mobility. On 3/12/24 at 12:17 PM, R65 was observed lying in bed. R65 was alert and oriented. R65 said he is supposed to get 2 showers a week and he has not had 2 a week since he was admitted . R65 said the first three weeks after he was admitted , he was not able to get out of bed, so they (staff) gave him a sponge bath once a week. R65 said they did not give him a sponge bath two times a week. R65 said since he has been able to get out of bed, they have started giving him a shower on Wednesdays. R65 said he has never had a shower or a bed bath twice a week. The bulletin board on the wall in R65's room had showers on Wednesdays and Sundays written on it. R65 said he has never received a shower on a Sunday. R65 said when he has a bowel movement, staff wash him up down there, but they do not wash him up daily or give him a sponge bath, adding, the only time he gets cleaned up is when he gets his shower on Wednesday, or they are cleaning him after a bowel movement. R65's hair appeared oily and flattened on his head. R65's 12/30/2023 transfer care plan showed he had an impairment in transfers and/or standing balance. On 3/13/24 at 1:10 PM, R65 said he is waiting for someone to get him up out of bed. R65 said he has physical therapy soon. R65 said he asked around 10:00 AM, and again around 11:30 AM or so. R65's call light was on. V5 (CNA) came in and asked R65 to give her 7-10 minutes and she will come in and get him up. R65 said has not received a shower yet and he usually gets his shower on Wednesday morning. At 1:34 PM, V5 and V4 (Registered Nurse/agency staff) transferred R65 from his bed to the wheelchair using a sit-to-stand lift. On 3/14/24 at 10:07 AM, R65 was lying in bed. R65 said he is waiting to get out of bed. R65 said he asked when they were serving breakfast, then again around 9:30 AM, and again just now. R65 said if he does not get up soon, he will not be able to have therapy today, because the therapist is not going to be there this afternoon. R65 said he still has not received a bath or shower and he was supposed to have it the previous day. On 3/14/24 at 11:33 AM, V2 (Director of Nursing) said the residents should be showered twice a week, for hygiene purposes, and for the resident's self-esteem and well-being. The facility's 10/29/2021 policy and procedure titled Bathing, showed all residents are showered one time per week. More frequent bathing or showering is given as needed and per resident preferences.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to ensure quality care was provided to a resident before leaving for dialysis (R2) and failed to obtain daily weights for residents with CHF (Congestive Heart Failure) for 2 of 2 residents (R54, R22) reviewed for quality of care in the sample of 26 and 1 resident (R2) outside of the sample. The findings include: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 3/13/24 at 9:04 AM, V4 (Agency Registered Nurse/RN) was standing in the middle of R2's hallway, at the medication cart, typing on his personal cell phone. When V4 looked up and realized he was being watched by the surveyor, he stopped typing and put his personal cell phone back in his scrubs pocket. At 9:07 AM, the surveyor approached V4 to observe medication administration. V4 stated, I'm about to go check [R2's] blood pressure (BP) because she has to go for dialysis at 10 AM. I'll take her BP and see if she needs her Midodrine. I don't think she takes any other medications before dialysis besides her pain medication. She told me she wants pain medication. V4 obtained an automated, wrist BP cuff and a pulse oximeter from the medication cart and entered R2's room. R2 was sitting up in her wheelchair, fully dressed. V4 told R2 he needed to check her BP and placed the wrist cuff on her left wrist. R2's left arm was shaking, and she was trying to keep her arm level with the over-bed table, in front of her. The BP cuff provided an error message. V4 adjusted the left wrist cuff and attempted to take R2's BP again. V4 instructed R2 to rest her arm on her lap. R2 placed her left arm in her lap. R2 had a nasal cannula in her nose, and it was attached to an empty, portable oxygen tank that was attached to her wheelchair. R2's pulse oximetry reading was 88-89%. (According to R2's vital signs report her average pulse oximetry reading is 95-97% on 2 L (Liters) of oxygen. Again, the BP cuff provided an error message. V4 attempted to re-adjust the left wrist cuff a third time. R2 looked at him and sighed loudly, Don't I need to rest my arm on my chest or above my heart? V4 gruffly replied, No, and placed R2's hand in her lap again. The wrist BP cuff provided another error message. V4 removed the wrist cuff from R2's left arm and attempted to place it on R2's right wrist. R2 had a hot pink band on her right arm that said not to use this arm. R2 yelled, No! You can't use that arm! V4 turned his back to R2 and left the room. R2 was anxious, restless, wringing her hands, and sighing loudly. V4 returned with an automated, upper arm BP cuff. V4 placed the BP cuff on R2's left arm and turned it on. V4 asked R2, Do they always have this much trouble getting your BP. R2 replied, No! They usually get it on the first try, it must be you! R2 started grumbling about how she doesn't like having male care givers. The automated, upper arm BP cuff also read an error message. At 9:16 AM, R2 declared, I have to get to dialysis. I can't be late. V4 told R2, This cuff didn't work either and since you said you don't want me taking care of you, then I will need to get another nurse. R2 yelled, I don't even care anymore. I just need you to do your job, so I can go to dialysis. I don't need any other medications. Just my Tylenol. I take the red and blue ones. I have my own in the cart. R2 started asking V4 questions about her transportation to dialysis and if she was going to be late. V4 turned and walked out of R2's room. V4 walked toward the nurses' station and spoke with V3 (Unit Manager). The surveyor stood outside R2's door and observed V4 from a distance. R2 was yelling out the door, Where did he go now? I have an appointment and I can't miss it! I already missed it on Monday! What is he doing? Somebody help me! R2's respiratory rate was increasing, and she was restless in her wheelchair. At 9:23 AM, V3 (Unit Manager) entered R2's room and said she need some clarification from R2. V3 stated, I never heard you say you didn't want a male nurse. I knew you didn't want a male CNA, the person that provides personal care, but I wasn't aware you had an issue with a male nurse. R2 replied, There is a new scheduler, and I don't think she realizes I don't like males taking care of me. I don't care about anything now. I just want to get out of here. I don't even care anymore. V3 continued to ask for clarification and R2 was wringing her hands. R2 replied, He can give me my meds, but all I need is Tylenol. I have dialysis today and I don't take any other meds. V3 left the room and walked to V4, standing at the med cart. V3 told V4 to administer her meds. At 9:26 AM, V4 went back into R2's room and explained he still needed to obtain her BP. At 9:27 AM, V18 (Agency RN) entered R2's room and asked if she was needed. V4 asked V18 for a BP cuff. (During this entire encounter, V4 made no attempt to obtain a manual BP cuff and stethoscope and obtain a manual BP reading). At 9:29 AM, V18 (Agency RN) returned with another automated wrist BP cuff. V4 applied the wrist cuff to R2's left wrist and R2 rested her arm on her chest. The digital display showed BP was 102/27 and heart rate was 72. V4 removed the BP cuff and left the room. V4 did not tell R2 what her blood pressure was, nor did he explain that R2 should take her Midodrine and express the importance of taking the Midodrine prior to R2's dialysis appointment. At 9:31 AM, V7 (Transport/Appointment Manager) arrived and asked if R2 was ready to. R2 replied, I told that nurse that I only needed my pain medicine before I go. I don't understand what is taking so long. V4 (Agency RN) told V7 that R2 needs a new portable oxygen tank before she can leave. V4 told the surveyor, Her BP is 108/37 (this is not the reading that showed on the BP cuff display). I have to give her the Midodrine. V4 had difficulty

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Face Sheet dated 3/13/24 showed diagnoses to include, but not limited to pleural effusion, chronic respiratory failure, generalized edema, end-stage renal disease, stroke with left sided weakness, dysphagia, coronary artery disease, presence of a cardiac pacemaker, and congestive heart failure. R2's facility assessment dated [DATE] showed she was cognitively intact. R2's Physician Order Sheet printed 3/13/24 showed, Midodrine 5 mg tablets, Give 3 tablets (15 mg) by mouth three times a day for hypotension. Hold for SBP (Systolic BP - the top number of BP) greater than 110. (R2's BP reading was 102/27.) R2's MAR showed she refused Midodrine 15 mg. (R2 was never told her BP result, nor was the importance of taking the medication presented to her. V4 did not take the Midodrine into R2's room). This MAR also showed that V4 did not document R2's BP. R2's Medication Administration Audit Report did not show V4 documented R2's BP. R2's Progress Note did not include a note that R2 refused the Midodrine, nor did it contain information regarding any education that was provided to R2 regarding her BP and Midodrine. R2's Provider Note dated 3/5/24 showed R1 was being seen for close monitoring after a recent hospitalization and required follow-up for pulmonary effusions and care following a thoracentesis (a procedure where fluid is removed from around the lungs). This note showed that R2 required supplemental oxygen and had oxygen saturations in the upper 90's while on 2 L via nasal cannula. R2's Care Plan last revised 11/28/23 showed, The resident needs hemodialysis every MWF (Monday-Wednesday-Friday) related to End-Stage Renal Failure. Resident has right arm AV fistula for dialysis access. The interventions include but are not limited to: .Administer/monitor effectiveness of medications as ordered (See Physician's orders/MAR). Avoid constriction on affected arm . Dialysis every MWF with chair time at 10 AM. Do not draw blood or take BP in arm with graft . On 3/14/24 at 11:30 AM, V7 (Transportation Manager) said she was familiar with R2. V7 said R2 is alert and oriented and able to make her needs known. V7 said R2 gets very anxious and likes things a certain way. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 11:37 AM, V3 (Unit Manager) said she was familiar with R2. V3 said R2 is able to make her needs known and can be demanding at times. V3 said R2 is alert and able to voice her concerns. The surveyor described the observation of the automatic BP cuffs not working for V4. V3 stared blankly and replied, Why wouldn't he just do a manual BP? That's what I would do, and we have plenty of manual cuffs available. I was taught to use your own ears and do it manual if you are having trouble. V3 pointed to a supply of manual BP cuffs at the nurses' station. The surveyor described the repeated attempts to obtain R2's BP with an automated cuff and R2's frustration. V3 stated, I would have just done a manual BP. The surveyor explained that V4 attempted to put the BP cuff on R2's right arm (where R2's dialysis fistula is located) and R2 refused. V3 replied, That shouldn't happen. The nurse should know that an arm with a dialysis fistula can't be used for BPs. The surveyor asked V3 what the hot pink arm band on R2's right wrist meant. V3 stared blankly and replied, I have no idea what you are talking about. We don't use arm bands here. V3 said R2's Midodrine had BP parameters for when she needs to take it. V3 said it's important for R2 to take her Midodrine before dialysis, especially if her BP is running low. The surveyor informed V3 that R2 did not receive her Midodrine before she left for dialysis, nor did V4 tell R2 her BP or explain the risk of not taking Midodrine. The surveyor explained that V4 reported an inaccurate BP to her and documented that R2 refused the Midodrine, but V4 never took the Midodrine into the room. V3 replied, That is so dangerous. [V4] should have at least explained to [R2] about her BP and the risk of not taking the medication. During dialysis, resident's BPs can drop even lower, that's why we check it and give the Midodrine before they go. Not to mention she is riding with transportation company, and they aren't licensed to handle medical emergencies. That shouldn't have happened. The facility's Medication Administration Policy reviewed 8/10/23 showed, All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis . Guideline: 5. Check medication administration record prior to administering medication for the right medication, dose, route, patient, and time. 6. Read each order entirely . 12. Follow special instructions written on label . 14. Document as each medication is prepared in the MAR . Explain procedure to the resident and give the medication .18. If medication is not given as ordered, document the reason on the MAR . 20. Vital signs are taken as required prior to medications and written on MAR. Medications are held as specified by the Health Care Provider . The facility's Charting and Documentation Policy reviewed 6/2/23 showed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Procedure: .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . 39543 2. R54's Admission Record (Face Sheet) showed an original admitted [DATE] with diagnoses to include acute/chronic congestive heart failure (CHF), acute and chronic respiratory failure, chronic obstructive pulmonary disorder (COPD), pneumonia, diabetes type II, morbid obesity, and chronic kidney disease. R54's 2/12/24 at 8:35 AM, Progress notes showed she was admitted to a local area hospital for low oxygen levels. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's 2/15/24 Medical Practitioner Note (Physician or Nurse Practitioner) showed she was admitted for pneumonia. The note showed, Assessment and Plan: HF (congestive heart failure) continue present management. Daily weights . R54's electronic health record showed from 2/14/24 through 3/13/24 (30 days) she was weighed 5 times, refused 4 times, and she was unavailable 2 times. The other 19 days showed no entries or not applicable. On 3/12/24 at 12:20 PM, R54 stated I have CHF, COPD, high blood pressure, chronic asthma, sleep apnea, chronic kidney disease. I have to go to the hospital because of my COPD and CHF. R54 said the facility does weigh her; however, the number of times she is weighed has fallen off and it's been a couple of weeks since they have weighed me. R54 said, It's important to weigh me because, if I gain weight, its extra fluid. On 3/13/24 at 12:59 PM, R54 said It's been two weeks since they weighed me .the doctor wants daily weights; they don't come daily to weigh me. R54 said she has refused to go down to be weighed when she feels weak however, R54 said, I rarely refuse weights because they rarely come to weigh me. On 3/13/24 at 1:52 PM, V11 (Certified Nursing Assistant/CNA) said the CNAs do the weights and document them in the electronic record or the CNA will tell the nurse and they will enter it into the record. V11 said she knows the residents on R54's hallway and she did not believe R54 was a daily or weekly weight. On 3/13/24 at 2:20 PM, V12 (CNA) stated she was R54's CNA and she said R54 was not a daily weight. V12 said she knows who the daily weights are by checking a binder at the nurses' station or checking the resident's care plan. V12 said if a resident refuses a weight, she will tell the nurse then reapproach the resident later. V12 said if the resident refuses again, she will document it as a refusal. On 3/13/24 at 2:35 PM, V12 presented the binder for R54's hallway. The binder showed 4 residents were daily weights on R54's section of the building. R54 was not one of the four residents listed as a daily weight. On 3/14/24 at 11:11 AM, V2 (Director of Nursing) stated, daily weights are generally ordered for CHF residents or residents with significant changes in their weight. V2 said the purpose of daily weights for CHF residents is to monitor for fluid buildup which can affect the resident's lungs and their breathing. V2 said R54 should be a daily weight and if she refuses the CNAs should reapproach the resident later. V2 said if the resident continues to refuse, they should document the refusal. 34491 3. R22's Admission Record, printed by the facility on 3/13/2024, showed he was admitted to the facility with diagnoses including acute kidney failure, chronic diastolic (congestive) heart failure, and hypertension. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Order Summary Report, printed by the facility on 3/13/2024, showed an order dated 2/29/2024 for Weight on day one and day two, then weight weekly and record for four weeks. The report listed the start date as 3/6/2024. R22's Order Summary Report also had an order showing CHF: Weigh daily and record every day shift for CHF. Weigh at the same time daily. This order date was listed as 3/9/2024, with a start date of 3/10/2024. On 3/13/2024, a review of R22's weights, in his electronic medical record, showed weights were obtained for R22 on 3/4/2024; 3/5/2024; 3/11/2024; and 3/12/2024. No weights were documented from R22's admission on 2/29/2024 through 3/3/2024. No weights were obtained on 3/6/2024 or on 3/7/2024 (per the 2/29/2024 order's start date), or on 3/10/2024 (per the 3/9/2024 order's start date). No other weights were listed under the vitals/weights in R22's tasks section. On 3/13/24 at 3:52 PM, V3 (Licensed Practical Nurse/Restorative Nurse) said the residents' weights are obtained by the restorative aides and entered into the electronic charting in the vitals tab under weights. V3 said there is no binder that contain the residents' weights. If the resident needs weights more frequently than monthly, the CNAs will get the daily or weekly weights and let the resident's nurse know. The nurse would enter the information into the resident's electronic medical record under the vitals/weights tab. At 3:56 PM, V2 (Director of Nursing) said the restorative aides get the weights and give them to V3. She enters the monthly weights into the residents' electronic charting near the beginning of the month. On 3/14/24 at 11:44 AM, V2 (DON) said if a resident has orders for daily weights, there is a reason why the order is to weigh daily. V2 said she would expect the staff to follow whatever the order is. The facility's policy and procedure 7/8/2022 policy titled Weight showed To establish a policy for the consistent, timely monitoring and reporting of resident weights .1. All residents will be weighed on admission, readmission, weekly for the first 4 weeks and then at least monthly. 2. Weekly weights will also be done with a significant change of condition, food intake decline that has persisted for more than a week, or with a physician order .4. The DON or designee to determine a list of reweighs will review all weights, upon completion. 5 Once the reweighs have occurred any resident with an unexplained significant or insidious weight loss will have a weight loss investigation. On 3/14/24 at 10:20 AM, V5 printed R22's weights since admission. 5 weights printed. V5 said when she brings up the weights, it shows all of his weights. V5 was asked to check R22's orders for how often he should be weighed. V5 looked in R22's orders and said he should be weighed every day. V5 said it is important to monitor the resident and do daily weights, to monitor for fluid overload, because we don't want that to happen. R22's weight history showed the following: 3/4/2024 245.00 pounds 3/5/2024 233.6 pounds 3/11/2024 210.0 pounds 3/12/2024 361.0 pounds (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/13/2024 362.0 pounds R22's weight history tab showed no reweighs were done to confirm the weight changes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on observation, interview and record review the facility failed to supervise a resident with swallowing difficulties during her meals and failed to safely transfer a resident. This applies to two of five residents (R237 and R1) reviewed for safety/supervision in the sample of 26. The findings include: 1. The facility face sheet for R237 shows an admitted [DATE] and diagnoses to include vascular dementia, severe protein-calorie malnutrition, and dysphagia. The functional abilities and goals assessment completed on admission shows R237 requires partial to moderate assistance with eating. On 3/12/24 at 9:30 AM, R237 was observed sitting in her bed with her breakfast tray in front of her not attempting to eat anything. On 3/13/24 at 10:44 AM, R237 was in bed with her breakfast tray in front of her. Approximately 15% of the meal was gone. R237 said if she could get the food to her mouth she would eat more because she was still hungry. On 3/14/24 at 9:00 AM, R237 was observed in bed attempting to eat her breakfast by herself. On 3/14/24 at 9:10 AM, V6 (Certified Nursing Assistant/CNA) said she had two residents on the hall that needed feeding assistance and she would help R237 as soon as she could. On 3/14/24 at 10:15 AM, V2 (Director of Nursing/DON) said all residents that need feeding assistance should be brought to the dining room for the staff to assist them and supervise them. The Physician orders for R237 dated 3/11/24 shows an order for one-to-one supervision for dysphagia (swallowing difficulties). The speech pathology daily note dated 3/5/24 shows R237 requires one to one feeding assistance. 34891 2. R1's face sheet printed on 3/13/24 showed diagnoses including but not limited to cerebral palsy, anemia, hypertension, and scoliosis. R1's facility assessment dated [DATE] showed substantial to maximal staff assistance needed for toilet transfers. R1's care plan showed a focus area start dated 2/1/23 for risk for falls due to balance and walking impairments and has a history of falls. R1's care plan showed a focus area start dated 12/27/22 for activities of daily living deficits due to impaired mobility from cerebral palsy and scoliosis. Interventions showed R1 is non-ambulatory with walking and requires staff assistance of one for toileting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 at 10:32 AM, R1 was seated on the toilet and was hunched over leaning against the bathroom wall. Two gait belts were observed hanging on a wall hook directly inside the resident's room. V16 (CNA) entered the bathroom and assisted R1 from the toilet to the wheelchair. V16 held R1's left arm and spoke loudly into her ear to say stand up. R1 was hard of hearing and did not immediately reply. V16 repeated the directions and R1 slowly stood while fumbling to find the wall grab bar. R1 held the bar with both hands and remained bent over while V16 performed pericare. V16 yelled into R1's ear to walk to the wheelchair. R1's spine was contracted, and she stepped in a shaky, shuffling manner. V16 held onto R1's buttocks and pushed her hips over to the wheelchair. R1 could be heard grunting and sighing while trying to pivot to the wheelchair seat. V16 did not use a gait belt at any time during pericare or at the transfer. On 3/13/24 at 8:49 AM, V15 (Licensed Practical Nurse) stated R1 cannot walk at all. She can bear weight, but only with help from the staff. She needs help to stand and pivot because of a poor gait and poor balance. R1 needs a gait belt to transfer safely, and the aides should be using it all the time. The gait belt is a safer way to hold her. It is used to steady and balance her. On 3/13/24 at 2:17 PM, V1 (Administrator/Registered Nurse) said residents that are a one person assist need supervision and a gait belt during transfers. Pivoting from surface to surface can get tricky. Gait belts are necessary to stabilize and guide the resident. Staff should not be pushing or pulling on residents. It is unsafe for the staff and the resident. The facility's Gait Belt policy last review dated 2/1/24 states under the guideline section: 1. Gait belts should be used by all staff when ambulating or transferring a resident .9. To transfer the resident, assist to standing position by holding the belt at waist and pivot resident to the chair.

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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** 34891 Based on observation, interview, and record review the facility failed to ensure an indwelling urinary drainage bag remained below the bladder and staff wore proper Personal Protective Equipment (PPE) during catheter care (R60). The facility also failed to ensure catheter care orders were in place, catheter tubing was secure, and a urologist follow up appointment was scheduled (R238) for 2 of 3 residents reviewed for catheters in the sample of 26. The findings include: 1. R60's face sheet printed on 3/13/24 showed diagnoses including but not limited to quadriplegia, pneumonia, anxiety, and neuromuscular bladder. R60's facility assessment dated [DATE] showed staff assistance needed for toilet hygiene, bathing, dressing, and transfers. The same assessment showed R60 uses an indwelling catheter for urinary incontinence and is always incontinent of bowel. On 3/12/24 at 11:20 AM, R60 was lying in bed covered with a light blanket. An empty blue dignity bag cover was noted hanging from the left side of the bed. V16 and V17 (Certified Nursing Assistants/CNA) entered the room with a mechanical lift and prepared to transfer R60 from the bed to the wheelchair. V16 removed R60's blanket and his urinary drainage bag was lying on the bed, underneath his left thigh. R60 was rolled into the mechanical lift sling and V17 hooked the drainage bag to the metal bar of the lift. The bag was at R60's shoulder level and remained there during the entire transfer. The CNAs wore gloves and surgical masks during the transfer. Neither aide wore any type of gown. On 3/13/24 at 2:20 PM, V1 (Administrator/Registered Nurse) stated catheter drainage bags should always remain below the bladder. It helps it to drain properly. Urine can backflow into the bladder and increase the risk of infection. Bags should not be laying on the bed or under a limb. That impedes the flow of urine. On 3/13/24 at 2:38 PM, V15 (Licensed Practical Nurse) was questioned regarding the required PPE needed in R60's room. V15 said gowns and gloves are needed anytime care is performed for R60 because he has an indwelling catheter. On 3/13/24 at 2:47 PM, V1 (Administrator/Registered Nurse) said residents with catheters are on enhanced barrier precautions. Gowns and gloves are necessary during all resident care, including transfers. Germs can be spread and put the resident at an increased risk of infection. R60's catheter care plan start dated 11/10/21 showed interventions including: Position catheter bag and tubing below the level of the bladder. R60's isolation care plan start dated 1/24/24 showed: Staff will wear required PPE while providing care . 36186 2. The facility face sheet for R238 shows an admitted [DATE] with diagnoses to include history of falls, dehydration, and retention of urine. The facility assessment dated [DATE] shows R238 to be cognitively intact and has a urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician orders for R238 shows orders for the urinary catheter began on 3/12/24. (20 days after admission to the facility.) The discharge paperwork from the hospital R238 was admitted from shows an appointment for a urology follow-up for 2/28/24. The operative report dated 2/18/24 for R238 shows the resident should be discharged with the urinary catheter and it should not be removed without discussing with the urology team. On 3/12/24 at 12:34 PM, R238 said she had to have a catheter put in under anesthesia while in the hospital and was wanting to know why she still had to have a catheter here at the facility. R238 said she has not seen the doctor about this and is getting very frustrated by it. On 3/12/24 and 3/13/24, R238 was observed with the catheter drainage tubing not attached to the tubing security strap on her left thigh. On 3/13/24 at 11:30 AM, V7 (Transportation scheduler) said R237's ride to the urology appointment was canceled due to the resident refusing to pay for the ride. A new appointment was not made for R238 due to her refusal. V7 said she will be making an appointment for her today. On 3/14/24 at 10:15 AM, V2 (Director of Nursing) said when a resident is admitted to the facility with a urinary catheter, orders must be in place for the care of the catheter. V2 said all appointments for follow-up care should be arranged and completed. If the resident cannot pay for the transportation, the facility should make other arrangements. If an appointment is not kept by the resident the nurse should be made aware of it and new arrangements should be made. The care plan for R238 dated 2/23/24 shows interventions to include do not remove the catheter without discussing with the urology team and catheter care per Physician orders. The Physician progress note dated 3/6/24 shows R238 was questioning the primary care doctor when her catheter could be removed. The same note goes on to show reluctance to remove the catheter since it needed to be placed under anesthesia, and it may be difficult to insert a new one if needed. The note shows to refer to urology as an outpatient. The facility policy with a review date of 2/18/23 for indwelling catheter care shows it is the policy of the facility to ensure that the residents receive care and services to prevent urinary tract infections in those residents with an indwelling catheter, in accordance with standards of practice.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure a resident's feeding tube pump was clean for 1 of 2 residents (R57) reviewed for tube feeding in the sample of 26. The findings include: R57's face sheet printed on 3/14/24 showed diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction, dysphagia (difficulty swallowing), and aphasia (communication disorder). R57's facility assessment dated [DATE] showed severe cognitive impairment and requires total staff assistance with bed mobility, transfers, dressing, eating, toileting, and hygiene. The same assessment showed additional diagnoses including human immunodeficiency virus disease (blood disease). The assessment showed R57 uses a PEG tube for nutrition (percutaneous endoscopic gastronomy tube inserted directly into the stomach). R57's March physician orders showed an order start dated 3/2/24 for: Enteral Feed Order one time a day .via feeding tube at 65 milliliters per hour .up at 5 PM, to run continuously until total volume of 1300 milliliters administered. On 3/12/24 at 10:40 AM, R57 was lying in bed. R57's feeding tube liquid formula was running through the pump. The formula bag was dated with a start date of 3/11/24. The pump was heavily smeared on the front and sides with a bright red substance. The substance appeared sticky and was clearly visible against the white colored feeding tube pump. On 3/13/24 at 10:36 AM, R57 was lying in bed. The feeding tube liquid formula was hanging on the pole and had a start date of 3/13/24. The pump still had the same red substance smeared across the device. At 10:45 AM, V13 (Licensed Practical Nurse/LPN) entered the room and stated the feeding tube runs daily from the PM shift and into the night shift. It is turned off on the day shift. V13 observed the dirty feeding tube pump and said this is bad. It looks like ketchup or chocolate. I am guessing it came from someone's dirty hands or gloves. V13 said she was not sure what it was and was unsure why it had not been cleaned sooner. V13 said the nurses need to clean it as soon as it is noted. V13 said the nurses on both units should have noted this sooner and cleaned it immediately. Dirty medical equipment can spread germs and cause infection. On 3/14/24 at 10:46 AM, V15 (LPN) said all the nurses are responsible for keeping the pumps clean. It is done on a daily basis and as needed. Nurses change his (R57's) feeding every day and can easily see if the pump needs to be wiped down. On 3/14/24 at 10:55 AM, V2 (Director of Nurses) stated resident feeding tube pumps should be cleaned by the nurses. Pumps should be wiped off as soon as any type of debris is noted on it. Dirty medical equipment causes a high risk of contamination and infection when left dirty. The pumps need to be cleaned on a daily basis, whether it is visually needed or not. R57's care plan showed a focus area start dated 7/8/21 related to impaired immunity. Interventions included: Keep the environment clean and people with infection away. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 12:01 PM, V1 (Administrator) stated feeding tube pumps are considered a semi-critical resident care item. The facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy last review dated 5/28/23 states: b. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin .Such devices should be free from all microorganisms .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to ensure a resident received oxygen therapy as prescribed by her physician for 1 resident (R2) reviewed for oxygen outside of the sample. The findings include: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/24 at 9:07 AM, the surveyor approached V4 (Agency Registered Nurse/RN) to observe medication administration. V4 stated, I'm about to go check [R2's] blood pressure (BP) because she has to go for dialysis at 10 AM. I'll take her BP and see if she needs her Midodrine. I don't think she takes any other medications before dialysis besides her pain medication. She told me she wants pain medication. V4 obtained an automated, wrist BP cuff and a pulse oximeter from the medication cart and entered R2's room. R2 was sitting up in her wheelchair, fully dressed. V4 told R2 he needed to check her BP and placed the wrist cuff on her left wrist. R2 had a nasal cannula in her nose, and it was attached to an empty, portable oxygen tank that was attached to her wheelchair. The needle on the portable tank was all the way to the end of the red section and it showed that the tank needed to be refilled. R2's pulse oximetry reading was 88-89%. (According to R2's vital signs report her average pulse oximetry reading is 95-97% on 2 L (Liters) of oxygen.) V4 left the room to obtain a different BP cuff and asked a staff member in the hallway to bring him a new portable oxygen tank because the one in R2's room was empty. Inside the room, R2 stated, I'm not getting air. R2 pulled the nasal cannula away from her nose and put it near her lips to feel for air. R2 stated, Nope, nothing seems to be coming out. R2's nasal cannula remained attached to the empty oxygen tank. R2 had an oxygen concentrator in the corner of the room that was running throughout this observation. V4 did not place R2's nasal cannula on the running oxygen concentrator. R2 was wringing her hands and had shallow, rapid respirations. R2 was voicing concerns with what V4 (Agency RN) was doing and the care he was attempting to provide her. At 9:16 AM, the surveyor asked V4 what R2's oxygen tank reading meant. V4 replied, It's not working, and she needs a new one. At that time, V5 (Certified Nursing Assistant/ CNA) entered the room with a new portable oxygen tank for R2. V4 continued to struggle with obtaining R2's BP, while the new tank sat next to R2, and she continued to be attached to the empty oxygen tank. V4 removed a seal from the oxygen tank, used a tool to open the new portable oxygen tank and it made a loud hissing sound. V4 then attempted to apply the piece to the tank that showed the liter flow and amount of oxygen in the tank. V4 turned on the tool again, looked at V5 (CNA) and stated, This tank is empty too Ma'am. V5 (CNA) replied, I got it from the new tank storage. R2 sighed loudly and showed signs of increasing agitation while asking what time it was. R2 stated, I have to get to dialysis. I can't be late. At 9:21 AM, V4 left R2's room and R2 remained on the empty oxygen tank. R2 was yelling out the door, Where did he go now. I have an appointment! What is he doing? Somebody help me! V4 walked toward the nurses' station and spoke with V2 (Unit Coordinator). At 9:26 AM, V5 (CNA) returned with another new oxygen tank. V4 entered the room, removed the seal on the tank, and used the tool to turn the top of the tank and a loud hiss of air was released. V4 turned the dial to 2L and again the reading appeared the tank was empty. R2 remained on the empty oxygen tank. At 9:29 AM, V4 entered the room. R2's nasal cannula was still attached to the empty tank and the oxygen concentrator continued to run in the corner, but there was a new oxygen concentrator parked next to it. V4 removed R2's nasal cannula from the empty oxygen tank, placed the tubing on the new oxygen concentrator, and attempted to turn it on. The new oxygen concentrator was not plugged in and did not turn on when he pushed the power button. Then V4 unplugged the running oxygen concentrator and plugged the new oxygen concentrator into the outlet. The new oxygen concentrator turned on when V4 pushed the power button and R2 was connected to 2 L (liters) of oxygen via the new concentrator at 9:31 AM. (R2 was connected to an empty oxygen tank from 9:07 AM until 9:31 AM.) V4 never attempted to re-check R2's pulse oximetry reading. At 9:31 AM, V7 (Transportation Manager) entered R2's room and asked if she was ready to go. R2 replied, I told that nurse that I only needed my pain medicine before I go. I don't understand what is taking so long. V4 (Agency RN) told V7 that R2 needs a new portable oxygen tank before she can leave. V7 pointed to the empty portable tank on R2's wheelchair and V4 replied, It's empty. She then pointed to the portable oxygen tank sitting next to R2 and V4 replied, It's empty too. She needs a new tank before she goes. V4 and V7 left R2's room. At 9:37 AM, V7 returned with another oxygen tank and stated, This one is full. If you can just switch it over, then we can get her to her appointment. V4 was at the medication cart. At 9:40 AM, V3 (Unit Manager) returned to the medication cart to see what help V4 needed. R2 was pleading from her room, I need to get going! What is happening? Why is no one helping me? At 9:49 AM, V3 (Unit Manager) entered R2's room, removed the seal of the oxygen tank, used the tool, and switched R2's nasal cannula from the oxygen concentrator to the new portable tank. V3 stated, This one is working. V3 pointed to R2's chair and asked, Is this an extra one? The surveyor explained that the tank attached to

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Face Sheet dated 3/13/24 showed diagnoses to include, but not limited to pleural effusion, chronic respiratory failure, generalized edema, end-stage renal disease, stroke with left sided weakness, dysphagia, coronary artery disease, presence of a cardiac pacemaker, and congestive heart failure. R2's facility assessment dated [DATE] showed she was cognitively intact. R2's Physician Order Sheet printed 3/13/24 showed an order dated 2/27/24 for continuous oxygen at 2L. R2's Vital Signs showed her pulse oximeter reading was generally 95-96% on 2L via nasal cannula. V4 did not document the 88-89% reading that he obtained. R2's Provider Note dated 3/5/24 showed R2 was being seen for close monitoring after a recent hospitalization and required follow-up for pulmonary effusions and care following a thoracentesis (a procedure where fluid is removed from around the lungs). This note showed that R2 required supplemental oxygen and had oxygen saturations in the upper 90's while on 2 L via nasal cannula. R2's Care Plan reviewed 11/28/23 showed, The resident has a PPM (pacemaker) in place related to atrial fibrillation . Interventions: Administer/monitor effectiveness of oxygen as ordered . R2's Respiratory Care Plan reviewed 11/28/23 showed, The resident has actual/potential altered respiratory status related to: CHF and ESRD (End Stage Renal Disease) . Interventions: .Administer oxygen as ordered via oxygen concentrator . R2's Cardiovascular Care Plan reviewed 11/28/23 showed, The resident has altered cardiovascular status r/t (related to) CAD (Coronary Artery Disease) with remote history of mitral valve repair due to acute chordal rupture, HTN (hypertension), HLD, CHF, CVA (stroke), a. fib status post (after) pacemaker placement . Interventions: .Administer/monitor effectiveness of medications . Monitor oxygen saturation as ordered/needed. Monitor vital signs as indicated . R2's Oxygen Care Plan reviewed 2/27/24 showed, The resident has oxygen therapy . Interventions: Provide assurance and allay anxiety . On 3/14/23 at 11:30 AM, V7 (Transportation Manager) said she was familiar with R2. V7 said R2 is alert and oriented and able to make her needs known. V7 said R2 gets very anxious and likes things a certain way. V7 stated, I really only deal with her when it has something do with transport. That's why I was out there the other day. With us using agency, the nurse (V4) was new to her and [V3 - Unit Manager] and I were trying to help him (V4) along. V7 said R2 was worried about the transport company leaving. V7 said the transport companies usually allow 10 minutes before the scheduled time and 10 minutes after, but V7 had missed transport in the past. V7 said R2 had been oxygen for as long as she can remember and stated, R2 is so worried it will run out, we have to send an extra portable tank with her. V7 stated, I found out that he (V4) wasn't putting the piece on the oxygen tank correctly, all those tanks weren't empty. The nurse (V4) just wasn't using the tanks properly. We had the tanks checked after R2 left and they were not empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/23 at 11:37 AM, V3 (Unit Manager) said she was familiar with R2. V3 said R2 is able to make her needs known and can be demanding at times. V3 said R2 is alert and able to voice her concerns. V3 said R2 doesn't like change and it can upset her. V3 stated, She's a creature of habit. She wants to make sure she is ahead of the time that transport is scheduled. V3 said the oxygen tanks are stored in a room and the new tanks have a seal on them. V3 asked, Did he (V4) removed the seals from the tanks? If he did than that was a full tank. If the top piece isn't properly attached to the oxygen tank, then it won't work, and it will look like it is empty. But if he took the seal off, that was a full tank. After all that, I called the oxygen guy, and he came out because I needed to know what was going on. He said those tanks were full, but the nurse wasn't using it right. The surveyor explained that R2's oxygen saturation was 88-89%. V3 looked in R2's EMR and stated, Her oxygen saturation is usually an average of 95-96% on the 2L. If it was 88-89%, I would have been trying to find out what was going on. I would check the tank and the tubing. That is an abnormal value for her (R2), so I would want to make sure she was immediately placed on a working oxygen tank. V3 said R2's oxygen saturation should have been re-checked to make sure she was okay. The facility's Oxygen Policy reviewed 4/2023 showed, It is the facility's policy to ensure that oxygen and nebulizer equipment use is compliant with the acceptable standards of practice .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on interview and record review the facility failed to have a provider evaluate a resident for the use of as needed antipsychotic medication after 14 days and failed to have a stop date for an as needed antipsychotic medication. This applies to 1 of 5 residents (R62) reviewed for psychotropic medications in the sample of 26. The findings include: R62's Admission Record (Face Sheet) showed an original admitted [DATE]. R62's Order Summary Report (Physician Order Sheet, provided 3/14/24) showed an active order for Haloperidol Lactate Oral Concentrate 2 milligrams per milliliter and to give 0.5 milliliters by mouth every 6 hours as needed for restlessness/agitation. The order shows it was started on 2/26/24 (17 days prior). The End Date column for this order was blank. R1's Order Summary Report showed R62 had not been on this medication since her admitted . R62's Progress Notes showed no provider evaluation for R62's as needed haloperidol on or about 3/11/24. R62's provider progress note on 3/4/24 at 12:18 PM (most recent documented progress note before 3/14/24) showed .Patient will continue all medications for stable chronic conditions . The note did not show an evaluation for haloperidol. On 3/14/24 at 11:01 AM, V2 (Director of Nursing/DON) stated she has been the facility's DON for a month. V2 stated the initial as needed (PRN) antipsychotics order can only be for 14 days. V2 stated she was not aware what is required to continue an as needed antipsychotic medication. V2 stated R62's haloperidol medication does not have an end date and the medication was not stopped after 14 days. R62's Psychotropic Drug Use Policy (reviewed 7/10/23) the purpose of the policy is to .promote the safe and effective use of psychotropic medications that are used in lowest possible dose and time frame and have indication for use that enhances the resident's quality of life. The policy showed, .If the prn medication is an antipsychotic, then it will be limited to 14 days and the resident must be evaluated by the practitioner if the order is going to continue as a prn .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to wear hairnets in the kitchen, failed to store thickener in a sanitary manner, and failed to maintain a lunch tray for a dialysis resident in a safe manner. This has the potential to affect all residents residing in the facility. The findings include: 1. On 3/12/24 at 10:11 AM the initial kitchen tour was initiated with V19 (Dietary Manager). V19 had a black hat on his head and his long, dark hair was pulled back in a low ponytail, resting on his shoulders. V19 had several shorter, loose strands of hair around his neck and ponytail. V19 did not have his hair contained in a hair net while he toured the dry storage, food preparation area, freezers, and refrigerators with the surveyor. During the time, the noon meal was being prepared in the kitchen. At 10:54 AM the surveyor returned to the kitchen to observe the pureed food preparation with V22 (Cook). V22 had a hair net on, but a large bunch of shoulder length hair was outside her hairnet and resting on her left shoulder. V22's hair remained out of her hairnet throughout the observation of the pureed carrots, rolls, and the second batch of the pureed carrots. V22 had a large pot of cooked carrots with the water it was cooked in. V22 added scoops of these carrots to the commercial blender and started to puree the food. While the blender was running, V22 add the liquids from the pot to the blender. Then V22 stopped the blender, stirred the carrot puree with a spatula. V22 opened a clear bin with a green lid. V22 said this was thickener and she was going to use it to reach the desired consistency. There was a white scoop, resembling a measuring cup inside the thickener. The scoop was resting on top of the thickener with the handle touching the thickener. V22 added a scoop and then a second scoop of thickener to the carrots. V22 returned the white scoop to the thickener bin and closed the lid. V20 (Regional Dietary Manager) tasted the pureed carrots and determined it was too chunky and told V22 to throw them away. V20 went to the back of the kitchen to start preparing fresh carrots. V22 disposed of the pureed carrots and then washed the blender in the 3-compartment sink. At 11:08 AM, V22 started the process to puree the rolls. V22 added the rolls to the blender, then added hot water. The container of thickener was sitting next to the blender with the white scoop still inside. V22 stopped the blender, stirred the bread, and used the white scoop to add thickener. V22 returned the white scoop to the container of thickener and closed the lid. At 12:00 PM, V22 started the second attempt of pureed carrots. V22's hair continued to be out of the hair net on the left side, resting on her left shoulder. The container of thickener was sitting next to the commercial blender and the white scoop remained inside, resting on top of the thickener. V22 added carrots, followed by liquid, and then she used to spatula to stir the mixture. V22 used the white scoop to add thickener and returned it to the container. The white scoop remained in the thickener while the surveyor continued kitchen observations. On 3/13/24 at 11:59 AM, V22 (Cook) was standing near the stove and flat top. V22's hair was out of the hair net and resting on her left shoulder. There was a large stock pot of soup, cooking on the stove. And she removed a baking sheet with hamburgers on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/13/24 at 12:05 PM, V19 (Dietary Manager) said hair nets should be worn by anyone entering the kitchen to prevent hair from getting in the food. V19 said part of the problem is that most of the kitchen staff have larger heads and thicker hair, but the vendor keeps sending him the incorrect size. V19 said scoops should not be left inside food items or thickener because it increases the risk of cross-contamination of the food. During this interview, V20 (Regional Dietary Manager) walked up and stated, I made sure to check all the scoops in the flour and sugar, but I didn't realize there was one in the thickener until you said something. The facility's Hair Restraints/Jewelry/Nail Polish Policy updated 7/22/23 showed, Policy: Food & nutrition services employees shall wear hair restraints and beard guards . Procedure: Hairnet, hat or hair restraint will be worn at all times in the kitchen . The facility's undated Food Storage Policy showed, All food stock and food products are stored in a safe and sanitary manner . 2. On 3/12/24 from 12:10 PM - 12:21 PM, V21 (Dietary Aide) was placing desserts on resident room trays and placing the trays into the insulated cart, for delivery. The cheesecake was served on small plates or dishes. In the kitchen, there was an open, metal rack with the cheesecakes resting on trays. V21 was collecting the cheesecake for the room trays from this rack. During this time, V20 (Regional Dietary Manager) told V21 to make sure the food is covered when it is delivered to the rooms. V21 loaded the trays into the insulated cart, closed the doors, and exited the kitchen. V21 pushed the insulated meal cart to the 100 hall and parked it, at the end of the hall near the nurses' station. At 12:23 PM, V23 (Certified Nursing Assistant/CNA) opened the insulated cart, left the cart where it was parked, and began delivering trays to resident rooms. All of the following observations include trays that had uncovered cheesecake during tray delivery. V23 delivered R46's tray to his room. At 12:24 PM, V23 obtained R70's tray from the cart, walked down the hall to his room and noticed R70 was not in his room. V23 walked back down the hall to the cart and returned R70's tray into the meal cart. At 12:26 PM, V23 walked down the hall to deliver R48's tray, returned to the parked cart, and obtained R78's tray. At 12:29 PM, V24 (CNA) removed R70's tray from the cart, placed it on top of the cart, removed a different tray from the cart, and returned R70's tray into the cart. V24 walked down the hall to R23 and R238's room. V24 stopped, read the Enhanced Barrier Precautions sign on the door, looked at the isolation bin, and walked back to the cart and returned the tray. At 12:32 PM, V23 (CNA) said out loud, I think [R34] must be in the dining room. V23 obtained R34's tray, walked past a small dining room and the nurse's station; continued past the bathrooms and main entrance; walked across the entire main dining room; and delivered R34's lunch tray to him. R34 was seated in the last row of tables, next to the windows. At 12:34 PM, V23 delivered R79's tray. At 12:36 PM, V25 (Admissions) walked up to the parked, meal cart, to assist with tray service. V25 removed R70's tray, walked to his room. V25 stated, He's not in his room, maybe he's in the dining room? V25 walked back down the hall and delivered R70's tray to him in the small dining room, near the hall. At 12:40 PM, V23 (CNA) walked down the hall to deliver R26's room tray. At the same time V25 took R238's tray. V25 sat R238's tray on top of the isolation cart and donned PPE. V25 spoke down the hall to V26 (Coordinator) and asked her to also bring R23's tray. V25 stated I have all the PPE on, I might as well give them both their trays. The cheesecake was not covered in any of these observations. The meal cart was parked in one location and the employees were walking the trays up and down the hallways, increasing the risk of cross-contamination of the resident's food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/13/24 at 12:05 PM, V19 said the dietary staff load the room trays and deliver the cart to the hallway. V19 said the expectation is the CNAs will move the meal cart down hall, near each resident's room, as they deliver the trays. V19 said that is done, so the trays are not traveling a long distance in the hallways. V19 said the main plate has an insulated lid, but the desserts are usually on a smaller plate or dish are not covered. The surveyor described the observations of the 100 hall room trays. V19 stated The trays shouldn't be traveling up and down the halls without the desserts covered. That's a risk of cross-contamination. There is a new DON (Director of Nursing) and we had addressed this issue with her. The facility's undated Room Service Policy showed, Meals shall be served in the patient/resident's room for those who are unable to eat in the dining room or prefer to eat in their room. Procedure: 1. Nursing staff will identify patients/residents who need in-room trays prior to the beginning of meal service. 2. Dining staff assembles in-room trays from the service area closest to the patient/resident's room . 4. All food and beverage items for Room Service (any food to be delivered to the resident's room whether during regular meal service, a Room Service Program, or other) will be wrapped or the dish in which it is be served will have a cover. 5. Nursing staff delivers trays to rooms. 34491 3. R2's Admission Record, provided by the facility on 3/14/24, showed she had diagnoses including chronic respiratory failure, end stage renal disease, congestive heart failure, anemia, and atrial fibrillation. R2's Order Summary Report, printed by the facility on 3/14/2024, showed R2 goes to dialysis every Monday, Wednesday, and Friday, with pickup for dialysis at 10:30 AM on these days. R2's facility assessment dated [DATE] showed she is cognitively intact and needs setup or clean-up assistance for eating. R2's Resident Choices care plan, with a revision date of 11/28/23, showed R2 chooses to not eat in the dining room. The care plan showed R2 has scheduled dialysis sessions three times a week and prefers to have her meals in her room due to fatigue. The care plan showed Meal trays to be delivered to resident room per her choice. On 3/13/24 at 1:02 PM, R2's lunch tray was on the bedside table in her room. R2 was out of the facility at dialysis. At 1:10 PM, V5 (Certified Nursing Assistant/CNA) was retrieving trays from the residents' rooms if they were finished eating. R2's tray still in room. R2 still at dialysis. At 1:16 PM and 3:30 PM, R2 was not back from dialysis and the lunch tray was still on her bedside table. At 3:34 PM, R2 was being propelled back to her room by V9 (Activity Aide/Receptionist). V9 heard telling R2 that was her lunch. At 3:37 PM, R2 was sitting in her room with the bedside table in front of her. This surveyor asked R2 if the facility ever sends food with her to dialysis for lunch. R2 said no, she just eats what is in her room when she gets back from dialysis. R2 asked for a towel so she could eat without getting her clothes dirty. This surveyor went and asked the V5 (CNA) to please go see what R2 needs. V5 said she would when she was finished charting something on the computer. V29 (Wound Nurse) was walking by and asked if she could help with anything. This surveyor asked her to please go see what R2 needed. V29 went in and then got R2 a towel. V29 asked R2 if she wanted her meal heated up. R2 said no she was just going to try it. R2 had potato salad on her fork. This surveyor told V29 that R2's tray had been sitting there since the lunch service and she should not eat it. V29 explained to R2 that the food had been sitting there too long and she would get her something else. V29 picked up R2's tray and said she was going to get her something else. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/14/24 at 10:02 AM, V9 (Activity Aide/Receptionist) said she took R2 back to her room after she returned from dialysis on 3/13/24. V9 said R2 asked her what the food was that was served, and she informed her it was sloppy joes and potato salad. V9 said she usually does not take R2 back to her room after dialysis, so she is not sure if the food is always sitting there when she gets back or not. On 3/14/24 at 11:53 AM, V2 (Director of Nursing/DON) said R2 should have been offered something else to eat and not food that has been sitting there for hours. Bacteria sets in and we don't want her to get sick. The facility's undated policy and procedure titled Food Temperatures showed Temperatures of TCS (temperature controlled for safety) foods shall be recorded before being served from the steam table .1. Food temperatures shall be checked at the end of cooking, at the start of service, recorded once on the Food Temperature Log or Production sheet. 2. Hot foods will be held at temperatures 135 degrees (Fahrenheit) or above and cold foods will be held at 41 degrees (Fahrenheit) or below prior to serving to maintain food safety .5. Inappropriate holding temperatures shall be reported to supervisor for corrective action or disposal instruction.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on interview and record review the facility failed to perform quarterly restorative assessments for a resident receiving restorative services then discontinued the resident's preferred restorative interventions without the resident's input or assessment. This applies to 1 of 2 residents (R13) reviewed for rehabilitation in the sample of 26. The findings include: R13's Admission Record (Face Sheet) showed an Original admitted [DATE] with diagnoses to include reduced mobility, abnormal posture, heart failure, and depression. R13's 12/12/23 Quarterly Minimum Data Set (MDS) showed she was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS showed R13 required partial/moderate assistance for rolling in bed and substantial/maximal assistance for transferring from bed to chair. The MDS showed R13 used a wheelchair for mobility. On 3/12/24 at 3:15 PM, R13 stated, I haven't done restorative for 3 weeks. Administration told us they weren't doing it because they were revamping the restorative program. R13 stated she enjoyed the restorative program she had been on. R13 stated she would rotate through three restorative exercises. R13 stated on one day she would do arm and leg exercises; on day two she would exercise on the bicycle; and on day three she would use a machine that would assist her with standing. On 3/14/24 at 9:43 AM V8 (Restorative Aide) said she did assist R13 with her restorative exercises. V8 said, the restorative programs she provided for R13 was bicycle, stand assist machine, and exercises. V8 said she would rotate through these different programs. V8 said R13 did enjoy her bicycle exercise and she was upset when it was taken away approximately 3 weeks ago. V8 said the restorative program has been wishy washy as the new restorative nurse is working on the program. V8 said prior to the new restorative nurse, the facility had been without a restorative nurse for a few months. V8 said, during the time without a restorative nurse she continued R13's previous restorative program. V8 said she was told by V3 (Restorative Nurse) that the bicycle and stand assist machine were not restorative programs and R13 was to only do Active Range of Motion exercises (exercises were the resident moves her limbs through their range of motion.) On 3/14/24 at 9:58 AM, V3 (Restorative Nurse) said she has been the restorative nurse since 2/26/24. V3 said the purpose of the restorative program is an attempt to maintain or improve a resident's level of function. V3 stated R13 was not assessed to use the bicycle and the standing machine is not a restorative program. V3 said R13's restorative program is now Active Range of Motion (AROM) exercises. V3 stated she was not aware R13 had been using the bicycle. V3 said R13 had not been assessed by her for restorative (despite removing previous assessment interventions.) V13 said restorative assessments should be done quarterly to ensure the current restorative interventions are appropriate and to assess for declines in level of function. V13 said R13 should have been assessed since June 2023. V3 said R13 may be able to use the bicycle if she has the staff to provide her the program. R13's Electronic Health Record showed her last Restorative Assessment (prior to 3/14/24) was completed on 6/20/23 (9 months prior). (continued on next page)

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	145980	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of St Charles, The	850 Dunham Rd St Charles, IL 60174

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's 6/20/23 Restorative assessment showed her interventions were to use the stand assist machine or active range of motion exercises. R13's Electronic Charting showed the stand assist machine intervention was discontinued on 3/2/24 (there was no corresponding restorative assessment completed on 3/2/24). R13's Care Plan showed she participates in a restorative nursing program: transfers and AROM Provide restorative programs/interventions as ordered/indicated . The facility's Restorative Nursing Program policy reviewed 8/18/23 showed, The screening will include the resident or their representative's input, choices, and expectations related to participating in the restorative nursing program . The policy showed, The designated nurse will evaluate the restorative documentation monthly to determine if there are any changes needed to the existing program and make a monthly progress note.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on observation, interview, and record review the facility failed to have the correct isolation signage for a resident with COVID-19 resulting in staff entering 1 resident's (R35) room with the incorrect personal protective equipment (PPE), and failed to wear the correct PPE while providing care for 2 residents (R65, R18) on Enhanced Barrier Precautions. This applies to 3 of 5 residents (R35, R65, R18) reviewed for infection control in the sample of 26. The findings include: 1. R35's Admission Record (Face Sheet) showed an original admitted [DATE]. R35's Order Summary Report (provided 3/13/24) showed an order for Contact and Droplet Isolation precautions for COVID-19 to begin on 3/5/24 for 10 days. R35's 3/5/24 Progress Note from 10:45 PM showed, Routine rapid covid test done, results positive, patient now isolated. R35's 3/11/24 Health Status Note from 6:14 PM showed, Resident on contact isolation no complaint of pain . On 3/12/24 at 10:01 AM, R35's door had a contact isolation sign on the door. The door did not have a droplet isolation sign. On 3/12/24 at 12:35 PM, V9 (Activity Aide/Receptionist) entered R35's room to deliver her lunch tray. R35 entered wearing a gown, gloves, and a surgical mask. R35 was not wearing a face shield or an N95. On 3/12/24 at 1:22 PM, V9 stated R35's door only showed contact isolation. V9 said, had the door said droplet isolation she would have worn an N95 and a face shield in addition to the gown and gloves. On 3/13/24 at 9:01 AM, R35's door showed only contact isolation signage. On 3/13/24 at 1:21 PM, V10 (Infection Preventionist) stated R35's room should have had a droplet and contact isolation sign. V10 said the correct PPE for COVID is gown, gloves, N95, and a face shield. V10 said the purpose of the isolation signage is to notify staff and families of the PPE required to enter a room. V10 said the purpose of PPE is to prevent the spread of infectious diseases, like COVID-19. The facility's COVID-19 Guidance (Updated May 25, 2023) policy showed, .If a resident is suspected or confirmed to have COVID-19, HCP (Health Care Providers) will wear an N95 respirator, eye protection, gown and gloves . 34491 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R65's Admission Record, printed by the facility on 3/13/24, showed he had diagnoses including chronic obstructive pulmonary disease with acute exacerbation, MRSA (Methicillin-Resistant Staphylococcus Aureus), Covid-19, moderate persistent asthma, type II diabetes mellitus, a tracheostomy, abnormalities of gait and mobility, and the need for assistance with personal care. R65's most recent comprehensive facility assessment dated [DATE], showed he was cognitively intact. R65's ADL (activities of daily living) care plan, dated 12/30/2023, showed he has an ADL self-care performance deficit. R65's care plan initiated on 1/23/2024 showed he is at risk for falls related to impaired mobility. 03/12/24 at 10:50 AM, R65 was lying in bed. R65 said he never sees anyone come in wearing a gown. only mask and gloves. R65 said even when they are transferring me to the toilet. R65 said he has been at the facility for several weeks. R65 said he has had the tracheostomy since August 30, 2022. On 3/13/24 at 1:34 PM, V5 (Certified Nursing Assistant/CNA) and V4 (Agency Registered Nurse/RN) transferred R65 from his bed to a wheelchair using a stand lift. A sign on R65's door showed R65 was on Enhanced Barrier Precautions (EBP) and staff should wear gloves, a mask and a gown when providing direct care for R65. Transfers was one of the direct care items listed on the sign for which staff must wear these items. V5 and V4 had gloves and a mask on. Neither V5, nor V9 had a gown on. At 1:38 PM, V5 (CNA) was leaning over R65's bedside table to get a cord for R65's laptop. While leaning over to reach for the cord, V5's clothing was touching R65's suctioning machine and tubing. R5 then made R65's bed. V5's clothing was touching R65's linens while making his bed. 3. R18's Admission Record, printed by the facility on 3/13/24, showed he had diagnoses including dysphagia (difficulty swallowing), congestive heart failure, muscle weakness, chronic kidney disease stage 3, and severe protein-calorie malnutrition. R18's Order Summary Report, printed by the facility on 3/13/24, showed he does not take food by mouth and has a feeding tube. The report also showed an order for Enhanced Barrier Precaution due to the feeding tube. R18's tube feeding care plan, with a revision date of 9/18/23 showed R18 requires tube feeding related to dysphagia. On 3/12/24 at 1:08 PM, V30 (Registered Nurse/RN) administered R18's bolus tube feeding. V30 only had gloves and a mask on. V30 did not wear a gown while administering R18's tube feeding. A sign on R18's door showed he was on Enhanced Barrier Precautions and instructed staff to wear a gown, gloves and a mask when providing direct care. On 3/14/24 at 11:33 AM, V2 (Director of Nursing/DON) said a resident is on enhanced barrier precautions if they have a feeding tube, a urinary drainage catheter, tracheostomy, or other respiratory equipment. V2 said enhanced barrier precautions are initiated to prevent any cross-contamination or any infection that the resident may have that has not been identified yet. It is also to protect the resident from anything the staff may have on them. V2 said V30 should have had a gown on when administering R18's bolus tube feeding because he is on enhanced barrier precautions. Gown, gloves, mask, and a face shield if any splashing. V2 said V5 and V4 should have had a gown on when transferring R65 with the stand lift. V2 said V5 cross-contamination could have occurred when V5's clothing touched R65's suction equipment when she was reaching over his bedside table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 7/2022 policy and procedure titled Enhanced Barrier Precautions showed Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of Staphylococcus Aureus and Multi-drug Resistant Organisms (MDROs). The policy showed examples of high contact resident care activities in which gowns, gloves, and masks should be worn include transferring residents and device care or use (i.e., central lines, urinary catheters, feeding tubes, tracheostomy) and wound care for any skin opening requiring a dressing.