STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146047	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Village	1200 East Grant Street Macomb, IL 61455

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 32189 Based on interview and record review, the facility failed to notify the state mental health authority to reevaluate a resident with a significant change in mental status for one of two residents (R20) with a significant change in mental status in a sample of 31 residents. Findings include: The Preadmission Screening and Resident Review (PASRR) policy, no date, documented the policy was reviewed and updated annually to ensure compliance with CMS regulations and referenced the State Operations Manual, Appendix PP Guidance to Surveyors for Long Term Care Facilities and State-Specific PASRR regulations and guidelines. The policy documented the Level 1 screening was conducted by the nursing facility and did not include guidance for a reevaluation when a resident had a significant change in condition. R20's OBRA (PASRR) Initial Screen form dated 5/17/19 documented R20 was not suspected as having a mental illness and did not require a level 2 screening. R20's Medical Diagnosis record documented R20 was admitted from another Skilled Nursing Facility on 10/22/2019 with Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbances, mood disturbances and anxiety, on 9/8/20 Unspecified Psychosis and on 10/27/21 Anxiety Disorder. R20's Minimum Data Set (MDS) section E-Behaviors dated 7/9/20 documented R20 developed physical and verbal behavior symptoms toward others; 8/20/21 documented R20 had delusions; 12/19/22 had physical symptoms such as hitting, scratching self, pacing, rummaging, public sexual acts, disrobing, throwing or smearing food or bodily waste or verbal symptoms like screaming or disruptive sounds and overall behaviors were worsening. R20's Care Plan documented on 5/10/23 R20 will be started on tracking for paranoid delusions noted by believing the facility is holding her hostage and family is trying to get rid of her. R20's medical record did not include documentation a new referral to the state mental health authority was made or a reevaluation was conducted by the state mental health authority for a significant change in mental status. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 2:27 PM, V2 (Director of Nursing) stated R20 was not referred or reevaluated by the state mental health and should have been revaluated with the change in R20's behavior.

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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. 30678 Based on observation, interview, and record review the facility failed to have documented rationale or appropriate diagnosis for the use of an antipsychotic for one (R101) of five residents reviewed for unnecessary medications in the sample of 31. Findings include: The Diagnosis Report for R101, documents the following diagnoses as: Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and Major depressive disorder, single episode. R101's medical record does not include any other mental health diagnoses. The Medication Review Report for R101, dated 2/20/25, documents a physician order as of 2/14/25 for Quetiapine 25 mg (milligrams) one tablet by mouth at bedtime for depression. The current Care Plan for R101 documents (R101) is at risk for side effects to psychotropic medications. R101 was admitted with order for Quetiapine 25mg for depression. Interventions include to monitor for side effects, effectiveness and to notify physician of any pharmacy recommendations. Pharmacy to review medication at least monthly and give recommendations. On 2/18/25 through 2/20/25 between 9:30 am through 3:00 pm R101 exhibited no behaviors to support the use of an antipsychotic. R101 was pleasant, cooperative, and denied having any psychological issues. On 2/20/25 at 2:25 pm, V2 DON (Director of Nursing) confirmed R101 is receiving the antipsychotic medication Quetiapine (Seroquel) for Depression and the diagnosis of Depression is not a clinical rationale for the use of this medication. V2 DON stated R101 will be discharging tomorrow or (V2) would have called R101's physician for clarification of the medication. V2 DON stated the facility pharmacist has not yet reviewed R101's medications.

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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. 32189 Based on observation, interview and record review, the facility failed to ensure safe and sanitary kitchens to prevent foodborne illnesses. This failure has the potential to affect 48 residents who reside in the facility. Findings include: The Facility Resident Census Roster and Facility Matrix/802, dated 2/18/25, were reviewed. The Census Roster documented 48 Residents residing in the Facility. The 1st Shift and 2nd Shift Dietary Aide Responsibilities handout, not dated, instructed the Dietary Aides to record equipment (dishwashers, freezers and refrigerators) temperatures at 7:00 AM, 11:00 AM and between 4:30 PM and 4:45 PM. On 02/18/25 at 9:30 AM through 10:00 AM, Kitchen 1, Kitchen 2, Kitchen 3 and Kitchen 4 were toured with V5 (Food Service Advisor). The following dishwasher temperature logs, freezer logs and refrigerator logs indicated temperatures were not monitored three times daily: Kitchen 1 - December 2024, 15 of 31 days and January 14 of 31 days were missing temperatures; Kitchen 2 - January 2025, 2 of 31 days were missing temperatures; Kitchen 3 - December 2024, 6 of 31 days, January 2025, 10 of 31 days and February 2025, 10 of 17 days were missing temperatures; and Kitchen 4 - December 2024, 5 of 31days and January 2025, 1 of 31 days were missing temperatures. V5 agreed the logs should have been competed three times daily and had not been. On 2/20/25 at 1:00 AM, V10 (Dietary Manager) reviewed the dishwasher, freezer and refrigerator temperature logs for Kitchen 1, Kitchen 2, Kitchen 3 and Kitchen 4 and stated temperatures had not been monitored as required and should have been monitored three times daily by the Dietary Aide at 7:00 AM, 11:00 AM and between 4:30 PM and 4:45 PM.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 32189 Based on interview and record review, the facility failed to ensure the Hospice's coordinated communication and required documents were available and accessible to the facility staff. This deficiency affects one of one resident (R34) reviewed for Hospice care management in a sample of 31 residents. Findings include: The Nursing Facility Contract with the Hospice provider, dated 4/20/22, documented Information/Documentation provided to Facility on admission and on-going: Most recent hospice plan of care; Hospice election form and any advance directive specific to each patient; Physician certification and recertification of the terminal illness specific to each patient; Hospice medication information specific to each patient; Hospice physician and attending physician orders specific to each patient; Copies of clinical notes after each visit; Instructions on how to access Hospice's 24-hour on-call system; Name and contact information for hospice personnel involved in care of each patient. R34's Care Plan documented R34 was admitted to Hospice services on 10/11/24 with a diagnosis of Atherosclerotic heart disease and lacks specific Hospice responsibilities/interventions. R34's medical record lacked a Hospice plan of care, Election forms, Physician certification of terminal illness and/or copies of clinical notes. On 2/19/25 at 2:05 PM, V14 (Registered Nurse/RN) stated she was the second shift nurse for R34. While looking through R34's record, V14 stated there should be a Hospice sticker on the front of the chart and a tab labeled Hospice that has all the Hospice's documentation. V14 confirmed there was no sticker and no Hospice documentation in R34's medical record and did not know which company provided Hospice care to R34. On 2/19/25 at 2:15 PM, V13 (Licensed Practical Nurse/LPN) stated We don't keep Hospice documentation. On 2/20/25 at 9:55 AM, V4 (Registered Nurse) stated We call the Hospice and verbally give updates and notify them if there is a change in condition. The Hospice Nurse and Hospice Aide come together twice a week to give (R34) a bath. On 2/20/25 at 2:30 PM, V2 (Director of Nursing) stated the Hospice residents should have a Hospice binder with all the required information in it on the unit and available for staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 30899 Based on observation, interview and record review the facility failed to ensure required Personal Protective Equipment was donned prior to entering a COVID Positive Resident (R33) Room. This failure has the potential to affect all 12 residents (R1, R7, R8, R11, R17, R22, R23, R28, R3, R36, R38, R43) who reside in R33's Household Unit. The facility also failed to follow Enhanced Barrier Precautions and ensure required Personal Protective Equipment was donned during cares for two residents (R14 and R29) of 12 residents reviewed for direct cares in a total sample of 31. Findings include: 1. Facility Policy/COVID-19 Outbreak Investigation and Management dated 1/10/25 documents: It is the policy of this facility to recognize and contain COVID-19 outbreaks and outbreak measures will be instituted whenever there is evidence of an outbreak as outlined below. The Centers for Medicare and Medicaid Services indicates An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. To implement immediate response for resident confirmed COVID-19 positive: Isolation Full PPE (Personal Protective Equipment) to prevent spread of the COVID-19 outbreak: Gloves, Gown, Eye protection, N95 mask or higher respirator. Facility COVID-19 Response Plan dated 5/23/23 documents: If a resident is suspected or confirmed to have COVID-19, HCP must wear an N95 respirator, eye protection, gown, and gloves. Infection Control tracking line list dated 2/2025 indicates R33 was COVID-19 and Influenza A positive on 2/17/25. On 2/18/25 at 10:50 am V8, CNA (Certified Nurse Assistant) entered and exited R33's room with a surgical-style mask. Posted on the outside of R33's door were the following signs: Airborne Precautions - Everyone Must: Clean their hands, including before and when leaving room. Put on a fit-tested N95 or higher level respirator (mask) before room entry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Remove respirator after exiting room and closing door. Door to room must remain closed. Contact Precautions - Everyone Must: Clean their hands, including before and when leaving the room. Provider and Staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. On 2/18/25 at 12:45pm V8, CNA donned PPE to bring lunch food items into R33's room. V8 wore a surgical-style mask into and when exiting R33's room. PPE equipment hanging on the outside of R33's door did include a supply of N95 respirator masks for staff to utilize. After exiting R33's room V8 stated that all of the isolation rooms are positive for Influenza A except for R33 as she is both Influenza A and COVID-19 positive. V8 stated We do the same PPE for all of the isolation rooms. On 2/19/25 at 11:10am V7, RN (Registered Nurse) stated an N95 mask is required to enter R33's room because she has COVID. V7 stated the other residents in isolation have Influenza A and staff only need to wear a surgical mask. On 2/21/25 at 2:45pm V3, Infection Preventionist stated an N95 mask is required when entering R33's room. 33970 2. The Facility's undated Enhanced Barrier Precautions policy documents It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Initiation of Enhanced Barrier Precautions: a. enhanced barrier precautions will be initiated for residents with any of the following: ii. Chronic wounds (pressure ulcer stage III & IV, diabetic foot ulcers and venous ulcers) >6 weeks old, even if resident is not known to be infected or colonized with a MDRO. iii. Indwelling medical devices (Central Lines, Urinary Catheters, Gastronomy Tubes, and Tracheotomy), even if resident is not known to be infected or colonized with a MDRO. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's undated Enhanced Barrier Precautions documents Implementing Contact versus Enhanced Barrier Precautions has wound or indwelling medical device, without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO: Contact Precautions: no; Enhanced Barrier Precautions: yes. High-contact resident care activities include: g. device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: any skin opening requiring a dressing. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. The facility's Enhanced Barrier Precautions signage documents everyone must: clean their hands, including before and entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing lines, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. R29's Physician Order Sheet dated February 2025 documents Indwelling catheter for neurogenic bladder. On 2/19/2025 at 11:30 AM V5 (Certified Nurse Aid) performed catheter care. V5 only used gloves as PPE (Personal Protective Equipment) during catheter care. On 2/19/2025 at 1:00 PM V5 (Certified Nurse Aid) confirmed that R29 is in Enhanced Barrier Precautions and that she should have worn a gown while performing catheter care. R14's Physician Order Sheet dated February 2025 documents Silver hydrogel ointment to wound and cover with (gauze dressing) daily and PRN (as needed). On 2/19/25 at 2:00 PM V7 (Registered Nurse) performed wound care as ordered. V7 only used gloves as PPE (Personal Protective Equipment). On 2/19/25 at 2:10 PM V7 (Registered Nurse) confirmed that R14 is in Enhanced Barrier Precautions and that she (V7) should have worn a gown while performing wound cares.