| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6009765 | A. BUILDING: _____ B. WING _____ | 09/21/2022 |

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| S 000 | Initial Comments<br><br>Annual Licensure and Certification Survey<br><br>Complaint Investigation # 2267553/IL151428 - F695, F725, F880 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br>1 of 4<br>300.610a)<br>300.1210b)<br>300.1210d)2)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>These Requirements were NOT MET as evidenced by<br><br>Based on observation, interview and record review, the facility failed to follow registered dietician recommendations and physician orders for enteral nutrition and weekly weights for one of two resident (R49) reviewed for enteral nutrition(tube feeding) on the sample list of 47. This failure resulted in R49 sustaining a 9.10% weight loss in one month and put R49 at risk for aspiration pneumonia.<br><br>Findings Include:<br><br>R49's MDS (Minimum Data Set) dated 8/8/22 documents R49 is alert and oriented, independent with decision making and has a Gastrostomy Tube.<br><br>R49's Request for Diet Change dated 6/6/22 by V47 RD (Registered Dietician) documents R49 remains on tube feeding and flush as ordered with no tolerance concerns noted. Requested to evaluate change in feeding schedule to allow for therapy. At this time, will suggest to change tube feeding and flush to 2 Cal HN at 50 ml (milliliter) per hour for 17 hours with flush to stay at 250 ml | S9999 | | |

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| S9999 | Continued From page 2<br>water every six hours. This request was accepted by V60 Physician. Please monitor weights weekly and monitor tolerance with increased rate. It does not document what hours R49's enteral nutrition should be ran.<br><br>R49's Physician Orders dated September 2022 document's R49 is NPO (meaning nothing by mouth) but may have ice chips at bedside, one at a time with nursing or speech therapy present. These orders do not document what hours R49's enteral nutrition should be ran.<br><br>R49's Interdisciplinary Resident Screen dated 9/12/22 by V45 Regional ST (Speech Therapy) documents a bedside swallow evaluation is not appropriate at this time due to R49 being NPO secondary to pharyngeal dysphagia. Tracheostomy and Gastrostomy Tube in place. A video swallow study is warranted to safely assess R49's swallowing.<br><br>The facility weight log documents the following weights for R49: August 2022 - 147.2 pounds, September - 133.8 pounds. This calculates to a 9.10% weight loss between August and September {1 month}.<br><br>R49's MAR (Medication Administration Record) for June, July and September 2022 do not document R49's ordered weekly weight. R49's August 2022 MAR was not in R49's medical record nor provided by V2 DON (Director of Nursing) upon request.<br><br>R49's Medical Record does not contain any Intake/Output tracking or Enteral Flow Record to document the amount of enteral nutrition received each day. | S9999 | | |

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| S9999 | Continued From page 3<br>On 9/18/22 at 7:53 AM, R49 was lying in bed, without enteral feeding running, eating a popsicle. No staff were present. A sign hanging on the wall above R49's head of bed that reads R49 is NPO. On 9/18/22 at 10:07 AM, R49 stated R49's enteral feeding runs a couple hours a day. On 9/19/22 at 8:57 AM, R49 was lying in bed without enteral feeding running.<br><br>On 9/19/22 at 1:27 PM V20 RN (Registered Nurse) entered R49's room and delivered a cup of italian ice {frozen dessert in pre-packaged cup} to R49 stating R49 can have items that melt like italian ice, freeze pops and ice chips but that R49 doesn't eat food. The sign remained above R49's bed documenting R49 is NPO. R49's enteral feeding was not running. R49 started eating the italian ice and V20 left the room, leaving R49 alone. On 9/19/22 at 1:52 PM, R49 was holding the empty italian ice container and stated R49 "ate it all." On 9/19/22 at 2:00 PM, R49 was at the Nurses Station requesting hot chocolate. V20 RN stated V20 would have to check and see if R49 could have it. At this time, V8 Activity Director walked by and stated V8 could get R49 some. On 9/19/22 at 2:10 PM, R49 was lying in bed with V20 present as V20 was providing cares. The sign documenting R49 is NPO was still on the wall above R49's bed. V8 brought a cup of hot chocolate into R49's room and left it on the bedside table for R49, and V20 did not instruct V8 that R49 could not have liquids. R49's enteral nutrition was not running. At this time, V20 stated R49's enteral feeding is to run from 1:00 pm - 6 am. V20 completed cares on R49 and left the room. On 9/19/22 at 2:53 PM, R49's cup of hot chocolate was empty. R49 stated "I (R49) drank it all." On 9/19/22 at 3:29 PM, R49 was lying in bed and enteral feeding was not running. | S9999 | | |

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| S9999 | Continued From page 4<br><br>On 9/20/22 at 9:18 AM, V3 ADON (Assistant Director of Nursing) stated V3 was not able to find any Intake/Output documentation for R49.<br><br>On 9/20/22 at 9:31 AM, V8 Activity Director stated V8 was not aware R49 was NPO explaining, V8 was just trying to help as V8 heard R49 requesting hot chocolate. V8 stated V8 had observed R49 drinking hot chocolate again later in the day.<br><br>On 9/20/22 at 10:01 AM, V2 DON (Director of Nursing) stated prior to V2 starting at the facility, the floor staff had decided that popsicles were okay for R49 to have, because "it was kind of like ice" but R49 should not have had the italian ice or hot chocolate.<br><br>On 9/20/22 at 1:36 PM, V45 Regional ST stated V45 does not know where R49's original order for NPO with ice chips only if nursing or ST were present came from because R49 hasn't been seen by ST at the facility but based on R49's complexity, V45 thinks it was an order based off of a prior video swallow test. V45 stated popsicles and italian ice are not in the same category as ice chips, explaining they would all be considered a thin liquid but the popcile and italian ice would not be a small amount and that hot chocolate would not be acceptable for R49 either; "unless the physician said that was okay, it would not be okay to give it." V45 stated when V45 got the recommendation for a swallow evaluation, V45 didn't feel it would be safe to evaluate R49 without a video swallow because "you can't see exactly what is going on without the video and (R49) has difficulty swallowing." V45 explained R49 could aspirate of popciles, italian ice and hot chocolate leading to aspiration pneumonia. | S9999 | | |

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| S9999 | Continued From page 5<br><br>On 9/21/22 at 2:28 PM, V47 RD stated without having access to R49's chart for review, V47 does not know what would cause R49's weight loss however it is theoretically possible that without the facility following physician orders of the amount of feeding R49 is to receive, R49 could loose weight. "The enteral feeding needs that I (V47) have calculated are what (R49) needs to maintain (R49's) weight" as R49 is NPO.<br><br>The facility Enteral Feedings Policy dated February 2008 documents enteral feedings will be provided when it has been determined that oral feedings are not sufficient to meet the physical requirements and the resident/responsible party and physician deem enteral nutritional support is appropriate. The Dietician/Consultant will monitor all diet orders for tube feedings and will recommend as appropriate changes in product according to resident needs. This policy includes a Enteral Flow Record that is to be completed each day that documents the time the feeding started, rate, and shift total of infusion.<br><br>(B)<br><br>2 of 4<br>300.610a)<br>300.1210b)<br>300.1210d)2)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the | S9999 | | |

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| S9999 | Continued From page 6 | S9999 | | |

medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

These Requirements were NOT MET as evidenced by:

Based on observation, interview and record review, the facility failed to obtain and/or follow orders for tracheotomy care, perform hand hygiene to prevent contamination during tracheostomy care, ensure extra tracheostomy tubes and supplies were at bedside and in working order, and failed to date and change oxygen tubing for six of 6 residents (R11, R49,

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| S9999 | Continued From page 7<br>R57, R72, R42 and R182) reviewed for respiratory care on the sample list of 47. These failures resulted in psychosocial harm to R182 when the oxygen tubing became disconnected from the tracheostomy tubing, causing R182 to panic due to being scared R182 was not going to be able to breath.<br><br>Findings Include:<br><br>The facility Tracheotomy Care Policy dated 3/29/2019 documents trach (tracheostomy) care should be performed, once per shift or as often as required to maintain patency of the airway and minimize the risk of infection. When the trach tube is fenestrated, inner cannula is to be in place during suctioning or bagging. A replacement trach tube is to be kept at the head of the bed at all times, clearly visible. When providing trach cares: obtain a new trach kit, suction the resident if needed, remove the old trach dressing, open the new kit, obtain the proper size inner cannula and open package, remove oxygen source, unlock, remove and discard the disposable inner cannula, replace inner cannula with sterile disposable inner cannula and replace the appropriate oxygen source, all while using Universal Precautions. With a sterile swab and sterile water and/or 1/4 to 1/2 strength hydrogen peroxide solution, cleanse the area immediately adjacent to the stoma and the base of the trach tube. Take extra precaution not to allow solution to enter the stoma. With a gauze 4 by 4 soaked in sterile water, rinse the area just cleaned. Dry the stoma area with a gauze 4 by 4. Replace sponge behind the trach plate and replace oxygen. To change the neck ties/collars: thread the long narrow fastener tabs through the flanges on the trach tube, bringing it back over the flange and adhere it to the soft material on the band. | S9999 | | |

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| S9999 | Continued From page 8<br><br>1.) R182's Nursing Progress Notes dated 9/2/22 document R182 was admitted to the facility with a tracheostomy present and 5 liters of oxygen being bled into it.<br><br>On 9/20/22 at 2:29 PM, V2 DON (Director of Nursing) stated trach care is to be completed twice a day. If they are admitted without orders, the admitting nurse should call and get orders, specific to the resident. Care consists of removing the inner cannula and cleaning it or if it has disposable inner cannula, replacing it, cleaning around the site and changing the collar. There should be an extra trach at the bedside. V2 stated R182's neck is too big and our trach collars aren't big enough to go around it. V2 explained the contract RT (Respiratory Therapy) company uses came to evaluate R182 three or four days after admission and ordered supplies but they haven't came in yet. V2 also stated the facility does not have an extra trach for R182. V2 explained V46 (R182's family) was to bring it in but didn't.<br><br>On 9/21/22 at 10:02 AM R182 was lying in bed with oxygen being bled into R182's trach. The oxygen tubing was not dated and there was no extra trach at R182's bedside. R182 stated, V182 does not feel the facility provides trach care as often as they should, "they only do it when I ask." R182 also stated the facility does not have an extra trach for R182 or the right trach collar, therefore it has not been changed since admission. R182's white trach collar was discolored with a brown substance around the insertion site/stoma. R182's also stated R182 had a problem with the oxygen humidifier tubing that is bled into R182's tracheostomy tubing;" it had popped off during the night, a few days prior." | S9999 | | |

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| S9999 | Continued From page 9<br><br>R182 stated R182 put R182's the call light on and it took staff over 30 minutes to get to R182. R182 explained R182 was banging R182's cup on the overbed table to try and get staff's attention. R182 further explained, "I'm (R182) new to having a tracheostomy and was very concerned. I (R182) was scared that I (R182) wasn't going to be able to breath and started to panic." R182 stated since staff were not answering R182's call light, R182 called V46 (R182's Family) and requested for V46 to call the facility to summons help.<br><br>R182's September 2022 Physician Orders do not document any orders for tracheostomy care; how often cares should be completed including cleaning and suctioning or the type and size of tracheostomy.<br><br>R182's TAR (Treatment Administration Record) dated September 2022 does not document when trach care has been provided.<br><br>On 9/21/22 at 10:57 AM, V20 RN (Registered Nurse) performed trach care on R182 using distilled water. The old 4 by 4 gauze had a moderate amount of yellowish/brownish secretions on it. V20 did not change out the soiled trach collar.<br><br>On 9/21/22 at 11:02 am, V46 confirmed that on 12/16/22 around 12:30 am - 1:00 am, one of R182's tubes from the trach to the Oxygen had fallen out and R182 used the call light for help, but nobody was coming so R182 had video called V46 asking V46 to call the facility and ask for help. "(R182) was starting to panic. I (V46) called the facility and nobody answered. I (V46) then called (R182) back and (R182) said nobody had came in {to R182's room}. We {V46 and R182} went back and forth like that for 20 | S9999 | | |

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| S9999 | Continued From page 10<br><br>minutes and still no answer. I (V46) was calling (R182) back to tell (R182), just to call 911 because (R182) was so scared when I (V46) got a text from (R182) saying staff finally came in."<br><br>2.) R49's September 2022 Physician Orders documents an order for trach (tracheostomy) care every shift, oxygen at 35% to maintain oxygen saturation above 92%, and to change the trach once a month.<br><br>On 9/18/22 at 7:53 AM, there was no extra trach visible at R49's bedside. On 9/18/22 at 10:15 AM, R49 was lying in bed with oxygen being bled into R49's trach at six liters. The oxygen tubing was not dated.<br><br>On 9/19/22 at 1:25 PM, R49 stated staff only complete trach care and suctioning every few days. R49 also stated staff have changed R49's trach once, "a long time ago." Humidifier on humidified oxygen running into trach was empty.<br><br>R49's MDS (Minimum Data Set) dated 8/8/22 documents R49 is alert and oriented.<br><br>R49's TAR (Treatment Administration Record) dated May 2022 - September 2022 does not document R49's trach was changed monthly as ordered or that trach care is completed every shift as ordered.<br><br>On 9/19/22 at 2:09 PM, V20 RN (Registered Nurse) entered R49's room to perform trach care. V20 stated R49's extra trach and down sized trach should be hanging on the wall but it isn't there. V20 checked all of R49's drawers in R49's room and couldn't find the extra trach. At this time, V20 stated R49's oxygen should be humidified and confirmed the humidifier was | S9999 | | |

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| S9999 | Continued From page 11 | S9999 | | |

empty. V20 set up trach care supplies on the overbed table with a hand towel on it. V20 did not disinfect the table prior to setting up the supplies and did not change out the hand towel. V20 then grabbed an open, undated bottle of normal saline from R49's bedside table, that was 3/4 used. V20 opened the trach cleaning tray, applied left sterile glove, opened used normal saline bottle with V20's right hand then placed it on the hand towel. V20 then applied the right sterile glove, picked up the normal saline and poured it into the cleaning tray (with sterile gloves on). V20 dipped the sterile applicator into the normal saline and cleansed around the trach insertion site. V20 then took a pipette and dipped it into the normal saline and cleaned around the hard plastic flange of trach stating, "these are normally used to clean the inner cannula but (R49) gets so much build up around the trach, I (V20) like to use it to clean it off." V20s scrubbed the flange around the trach and cleansed off a moderate amount of dark brown crusted substance. V20 then stated V20 was done with trach cares. When asked about cleaning the inner cannula, V20 stated "it was replaced last week when RT (Respiratory Therapy) was at the facility so there was no need to clean it."

On 9/20/22 at 2:29 PM, V2 DON (Director of Nursing) stated trach care is to be completed twice a day. Care consists of removing the inner cannula and cleaning it or if it's a disposable, replacing it, cleaning around the site and changing the collar. There should be an extra trach at the bedside.

3.) On 09/18/22 at 8:34 AM R11 was lying in bed wearing oxygen at 2 L (liters)/Minute per nasal cannula. The oxygen tubing was not labeled with a date. The refillable humidification bottle was

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| S9999 | Continued From page 12<br>dated 6/1/22. On 9/20/22 at 8:26 AM R11 was lying in bed wearing oxygen at 2 L/minute. There was no date on the tubing.<br><br>R11's September 2022 Physician's Orders Summary (POS) documents to change R11's oxygen tubing weekly. R11's August and September 2022 Treatment Administration Records (TARs) only document R11's oxygen tubing was changed once between 8/1 and 9/20/22.<br><br>On 9/20/22 at 4:53 PM V2 Director of Nursing stated oxygen tubing should be changed weekly and recorded on the TAR, and should be labeled with a date.<br><br>4.) On 09/18/22 at 9:45 AM R42 was lying in bed wearing oxygen at 2.5 L/minute per nasal cannula. There was no date labeled on the tubing or refillable humidification bottle.<br><br>R42's September 2022 POS does not include orders for oxygen or to change the oxygen tubing regularly. R42's August and September TARs do not document a schedule for changing R42's oxygen tubing, or administration of oxygen.<br><br>R42's Nursing notes document R42 used oxygen periodically in June, July, August, and September. R42's Hospital Discharge Orders dated 6/23/22 documents R42 was diagnosed with Pneumonia and treated with antibiotics.<br><br>5.) On 9/18/22 at 9:26 AM and on 9/20/22 at 9:00 AM R72 was lying in bed wearing oxygen at 3 L/minute per nasal cannula. The oxygen tubing was not labeled with a date, and the refillable humidification bottle was dated 6/1/22. | S9999 | | |

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| S9999 | Continued From page 13<br>R72's Care Plan dated 8/8/22 documents R72 uses inhalers and oxygen as needed with interventions to administer oxygen as ordered.<br><br>R72's September 2022 POS documents to administer oxygen at 2 L/minute per nasal cannula as needed, and to change the oxygen tubing weekly on Saturdays. R72's TAR documents R72's oxygen tubing was changed once between 8/6/22 and 9/20/22.<br><br>6.) R57's Physician Order Sheet (POS) dated 9/1/22 through 9/30/22 documents diagnoses including Chronic Kidney Disease Stage 5, Hypoxia, and Fluid Overload. The same POS does not document any orders for oxygen.<br><br>On 9/18/22 at 10:06am, R57's was resting in bed with 4 liters of oxygen continuously supplied via nasal cannula and an oxygen concentrator. The oxygen tubing was not dated. R57 stated staff do not change R57's oxygen tubing and R57 usually wears oxygen at night.<br><br>On 9/20/22 at 10:10am, R57's was resting in bed with 4 with liters of oxygen continuously supplied via nasal cannula and an oxygen concentrator. The oxygen tubing remained undated. R57 confirmed that the oxygen tubing had not been changed at this time.<br><br>R57's Hospital Pulmonary Progress Note dated 9/8/22 documents: Plan: Can discharge home with supplemental oxygen PRN (as needed) to maintain O2 (oxygen) saturation >90%.<br><br>R57's Care Plan does not document a focused care area or parameters for R57's oxygen use.<br><br>R57's Treatment Record (September 2022) fails | S9999 | | |

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| S9999 | Continued From page 14<br>to document any oxygen tubing changes or humidifier bottle changes for R57.<br><br>The facility Oxygen Therapy Policy (August 2003) documents: "Oxygen therapy may be used provided there is a written order by the physician. The order must state liter flow per minute, mask or cannula, time frame. Change oxygen tubing/mask/cannula/and/or tracheostomy mask on a weekly basis. Date tubing changes and document on the treatment sheet. If humidification is indicated, date prefilled bottles when changed. If using unfilled humidifier bottles; empty, rinse and refill daily with distilled water, and wash with soap and water as needed. Humidifier changes and cleaning is to be documented on the treatment sheet at the time of occurrence."<br>(B)<br><br>3 of 4<br>300.610a)<br>300.1210b)<br>300.4040a)1)2)3)4)5)6)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. | S9999 | | |

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| S9999 | Continued From page 15<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>Section 300.4040 General Requirements for Facilities Subject to Subpart S<br><br>a)The psychiatric rehabilitation services program of the facility shall provide the following services as needed by facility residents under Subpart S:<br><br>1) 24 hours of continuous supervision, support and therapeutic interventions;<br><br>2) Psychotropic medication administration, monitoring, and self-administration;<br><br>3) Case management services and discharge preparation and training;<br><br>4) Psychiatric rehabilitation services addressing major domains of functioning and skills development: self-maintenance, social and community living, occupational preparedness, symptom management, and substance abuse avoidance;<br><br>5) Crisis services; and<br><br>6) Personal care assistance. | S9999 | | |

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| S9999 | Continued From page 16<br><br>These Requirements were NOT MET as evidenced by:<br><br>Based on observation, interview and record review the facility failed to provide behavioral health services and interventions to meet the needs of one (R14) of nineteen initial residents sampled in a total sample list of 47. This failure resulted in ongoing behaviors which resulted in R14 harming R14's self.<br><br>Findings include:<br><br>The facility assessment reviewed date 5/22 documents, "Common Diagnosis, Physical or Medical Conditions Accepted (to the facility) but not limited to: Psychiatric/Mood Disorders: Psychosis (Hallucination, Delusions, et.) Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Intervention. Resident Support/Care Needs: Mental health and behavior: Manage the medical conditions and medication-related issue casing psychiatric symptoms and behavior, identify and implement intervention to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment care of individuals with depression, trauma/Post Traumatic Stress Disorder, other psychiatric diagnoses, intellectual or developmental disabilities." "Include dementia management training and resident abuse prevention training. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired."<br><br>On 2/21/22 R14 was admitted to the facility with | S9999 | | |

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the following diagnoses including: Closed Fracture of the Right Hip, Intellectual disability, Anxiety, Cancer of the Prostate, Psychosis with Behaviors and Depression.

R14's Minimum Data Set dated 7/11/22 documents R14 as severely cognitively impaired.

On 9/21/22 at 10:30AM, R14 laid in bed. V34 Unit Aid was sitting outside of R14's room in eye view of R14. R14 appeared tired and disheveled. V34 Unit Aid said that R14 had to be watched all of the time because of his behaviors.

R14's progress notes document the following:
2/23/22 "Requires assist with all activities of daily living. Will yell out for whatever he wants even when he has the item."
2/28/22 "Up in chair and very agitated today. Was one to one and cursing, throwing things and spitting. Yells loudly and strips off clothing."
3/10/22 " Resident agitated, wanting to leave facility and slapped (unknown) peer."
3/16/22 "Resident punching and screaming at staff."
3/14/22 "Attempts to stand and transfer self despite unsteadiness. Takes roommates walker but does not use properly. Requires assist with activities of daily living and can be resistive. Takes medications and can be feisty at times with cares." "Up walking without assistance. Resists care and screaming that he wants to go home." "Resident hitting staff, pulled shade off of window again. Screaming about going home. Throwing pillow and blankets on the floor."
4/6/22 "Resident very agitated throughout the day. Up and walking around without wheelchair. Resident throwing items from nursing cart. Asking for staff that are not working."
4/7/22 "Resident showed aggressive behavior,

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slapping staff and spitting."
4/21/22 "Attempts to hit staff and self at times."
5/4/22 R14 was in another resident room (in the last room on the A wing) and when staff attempted to redirect, became violent, swinging and hitting staff, looking for a woman.

R14's 5/28/22 incident report documents that at approximately 5:30PM, R14 became enraged and punched a glass picture frame in the hallway of the facility resulting in glass in the right hand with a possible fracture. R14 was sent to the local hospital for evaluation and treatment. R14 was then sent to another local hospital and was returned to the facility at 6:00AM on 5/29/22 with orders to see orthopedics and to have the foreign body (glass) removed.

R14's 6/6/22 progress notes document, "Resident agitated, spitting, combative, throwing objects. Having (unknown) peer to peer altercations."

R14's 8/25/22 incident report documents R14 peer to peer altercation.

On 9/21/22 at 1:20PM, V4 Memory Care Unit Coordinator stated, "I have been doing individual training with staff on dementia/behavioral care. Most of the staff that I've trained no longer work here. Maybe half have the training."

On 9/21/22 at 12:00PM V1 Administrator stated, "I know that R14 has behaviors, can be agitated and aggressive. The staff try to redirect him and it doesn't always work. He is on one to one observation until we can get him discharged. We haven't had psychiatric services since he has been here (February 2022). In the spring of 2019 they just stopped coming and it hasn't restarted yet. We have a new company starting soon, but

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| S9999 | Continued From page 19<br>we have to get the consents signed before they will come. When they come (R14) will be first on the list to see them. I don't know if he was screened before he was admitted or not. We are just pushed so hard to take any admission that we are accepting residents with more and more behavioral issues because our corporation wants us to."<br><br>On 9/21/22 at 12:55PM, V2 Director of Nursing stated, "The staff lack the training to manage the behavioral needs of the residents. That is one reason we are excited to have the new behavioral health company starting. They are going to provide staff education and training as well as psychiatry for the residents."<br><br>(B)<br><br>4 of 4<br>300.697d)<br><br>Section 300.697 Infection Preventionists<br><br>A facility shall designate a person or persons as Infection Preventionists (IP) to develop and implement policies governing control of infections and communicable diseases. The IPs shall be qualified through education, training, experience, or certification or a combination of such qualifications. The IP's qualifications shall be documented and shall be made available for inspection by the Department. (Section 2-213(d) of the Act). The facility's infection prevention and control program as required by Section 300.696(e) shall be under the management of an IP.<br><br>d) Facilities with more than 100 licensed beds or facilities that offer high-acuity services, including | S9999 | | |

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| S9999 | Continued From page 20<br>but not limited to on-site dialysis, infusion therapy, or ventilator care shall have at least one IP on-site for a minimum of 40 hours per week to develop and implement policies governing control of infectious diseases. For the purposes of this subsection (d), "infusion therapy" refers to parenteral, infusion, or intravenous therapies that require ongoing monitoring and maintenance of the infusion site (e.g. central, percutaneously inserted central catheter, epidural, and venous access devices).<br><br>This requirement is not met as evidence by:<br><br>Based on observation, interview and record review, the facility failed to have a full time Infection Preventionist. This failure has the potential to affect all 77 residents residing at the facility.<br><br>Findings Include:<br><br>The facility Medicare/Medicaid Certification and Transmittal Form with a determination of approval date of 9/7/21 documents the facility has 123 licensed beds.<br><br>On 9/20/22 at 10:23 AM, V3 ADON/IP (Assistant Director of Nursing/Infection Preventionist) stated V3 only works at the facility part-time (less than 40 hours per week) as the ADON/IP due to taking a new position at a different facility.<br><br>On 9/21/22 at 2:00 pm, V2 DON (Director of Nursing) confirmed V3 does not work at the facility full time, but that V3 is still the Infection Preventionist.<br><br>The Resident Census and Conditions of Residents Form dated 9/19/22 documents 77 | S9999 | | |

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| S9999 | Continued From page 21<br>residents reside at the facility.<br><br>(C) | S9999 | | |