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	IL6000855	A. BUILDING: _____ B. WING _____	03/17/2025

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THE HAVEN OF BEMENT.	601 NORTH MORGAN BEMENT, IL 61813

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S 000	Initial Comments First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 7 300.615e) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) This Requirement is NOT MET as evidenced by: Based on interview and record review, the Facility failed to conduct background checks of residents within 24 hours of admission. This has the potential to affect all 37 residents residing in the facility. Findings include: The facility's policy titled "Identified Offender Facility Policy and Procedure" with the date of	S9999		

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2011 states: "It is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions."

On 3/16/25 a total of 10 residents files were reviewed for background checks. The following was documented:

R6 was admitted to the facility on 3/7/25. The facility's documentation for the Criminal Background Check was not done until 3/13/25.

R7 was admitted to the facility on 2/17/25. Facility documentation for the Criminal Background Check was dated 2/17/25.

R8 was admitted to the facility on 3/6/25. Facility documentation for the Criminal Background Check was dated 3/15/25.

R9 was admitted to the facility on 2/14/25 and the facility documentation for the Criminal Background Check was dated 2/17/25.

On 3/16/25 at 11:30 AM , an interview with V1 was conducted . V1 stated 2 of the admissions came in on a Friday night and I did not run them until I returned to work on the following Monday. The other two were just late.

The facility's midnight census roster dated 3/15.25 documents there are 37 residents residing in the facility.

(C)

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S9999	Continued From page 2 2 of 7 300.670a) 300.670c)1)2)3) 300.670d) 300.670e) 300.670f) 300.670g) Section 300.670 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and 3) Evaluate the effectiveness of disaster plans and procedures. d) Fire drills shall include simulation of the evacuation of residents to safe areas during at least one drill each year on each shift. e) The facility shall provide for the evacuation of physically handicapped persons, including those who are hearing or sight impaired. f) If the welfare of the residents precludes an actual evacuation of an entire building, the facility shall conduct drills involving the evacuation of	S9999		

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successive portions of the building under conditions that assure the capability of evacuating the entire building with the personnel usually available, should the need arise.
g) A written evaluation of each drill shall be submitted to the facility administrator and shall be maintained for one year.

These requirements are NOT MET as evidenced by:

Based on interview and record review the facility failed to conduct disaster drills and an evacuation drill annually and ensure personnel from all shifts were trained on these drills. This failure has the potential to affect all 38 residents in the facility.

Findings include:

On 3/15/25 at 11:25 AM V6 Maintenance Director stated V6 started working in this position in December 2024. V6 stated V6 will look to see if there is any documentation that disaster drills and an evacuation drill were conducted within the last year.

On 3/16/25 between 10:30 AM and 11:10 AM V1 Administrator provided the Snow Disaster Drill Inservice Attendance dated 1/15/25 which documents five employees were in attendance, all management staff. V1 provided the Tornado Drill Inservice Attendance sheet dated 4/25/24 which does not document any floor nurses were in attendance. V1 confirmed these were the only disaster drills conducted within the last year. V1 confirmed the facility had not conducted an evacuation drill within the last year. V1 confirmed the Snow Disaster Drill was only conducted with management staff and confirmed no floor nurses are listed on the Tornado Drill Inservice

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S9999	Continued From page 4 Attendance. The facility's Daily Census dated 3/14/25 documents a census of 37 residents. (C) 3 of 7 300.680a) 300.682a)1)4) 300.682b) 300.682c) 300.682h) 300.682i) Section 300.680 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the medical advisory committee or the advisory physician with participation by	S9999		

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nursing and administrative personnel.

Section 300.682 Nonemergency Use of Physical Restraints

a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:
1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective;
4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. (Section 2-106(c) of the Act)
b) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.
c) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical restraint is used.
h) The plan of care shall contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible progressive removal of

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physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical, mental or psychosocial well being.
i) A resident wearing a physical restraint shall have it released for a few minutes at least once every two hours, or more often if necessary. During these times, residents shall be assisted with ambulation, as their condition permits, and provided a change in position, skin care and nursing care, as appropriate.

These requirements are NOT MET as evidenced by:

Based on observation, interview, and record review the facility failed to obtain physician's orders, obtain consents, care plan and assess for the use of restraints for one (R5) of one resident reviewed for restraints in the sample list of 14.

Findings include:

The facility's Physical Restraint/Enabler policy dated 7/24/18 documents the following: Obtain consent from the resident or resident's representative prior to the physical restraint being applied. Obtain a physician's order for the restraint that includes the medical reason, the type of restraint, "release and reposition at least every two hours" and when the restraint should be used. Restraints should be released at least every two hours for repositioning, toileting, and skin care. The restraint should be included in the resident's care plan including the type, duration, and when the restraint should be used. Document quarterly the type of restraint used, the resident's response to the restraint and if a reduction plan has been implemented. Restraint elimination or

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reduction plans should be initiated 90 days after application.

The facility's Wheelchair Safety Belt policy dated 1/3/18 documents the need for the safety belt is assessed by the interdisciplinary team initially and quarterly. The belt should be released at least every two hours to meet the resident's care needs and positioning as specified in the physician's order.

During intermitting observations on 3/15/25 between 8:18 AM and 12:13 PM R5 was lying in bed on R5's right side, facing the right side of the bed which was positioned against the wall. The opposite side of the bed had an upright half siderail and a body pillow that was positioned underneath of the fitted sheet, along side R5 and the siderail. On 3/15/25 at 1:05 PM R5 was lying in bed on R5's right side with the body pillow and half siderail still in place as previously noted. V8 and V9 Certified Nursing Assistants used a full mechanical lift to obtain R5's weight. R5 was asleep and did not assist with the transfer or repositioning in bed. V8 stated the body pillow has been used for as long as R5 has been in the facility.

On 3/16/25 at 11:25 AM R5 was sitting in a reclining back wheelchair in the family room. There was a safety belt with a seatbelt style push button release mechanism tht was secured across R5's lap. R5 was asleep. V8 attempted to wake R5 to ask R5 to remove the safety belt. R5 did not wake and did not attempt to remove the safety belt. V8 stated R5 will hold items, but R5 isn't able to use R5's hands to disengage the safety belt.

R5's Minimum Data Set (MDS) dated 1/3/25

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documents R5 has severe cognitive impairment, is dependent on staff for Activities of Daily Living, and does not use restraints. R5's active Care Plan does not include problems, goals, and interventions for the wheelchair safety belt or body pillow restraints.

R5's Restraint-Enabler Evaluation dated 6/6/24 documents the use of a wheelchair safety belt related to poor sitting balance, poor control, and diagnoses of Cerebral Palsy and Seizure Disorder. This is the last documented assessment for this restraint in R5's medical record. There are no documented assessments for the body pillow. R5's medical record does not contain physician's orders or consents for the use of these restraints.

On 3/15/25 at 9:53 AM V4 Registered Nurse stated R5's body pillow is used to keep R5 from rolling out of bed and R5 is not able to remove the pillow. R5 stated R5 uses a full mechanical lift for transfers, but R5 has rolled out of bed before. V4 stated R5 is nonverbal.

On 3/15/25 at 12:56 PM V2 Director of Nursing stated V2 was unsure if R5's body pillow would be considered a restraint. V2 stated R5 uses the wheelchair safety belt and was unsure if R5 was able to remove the device on command. V2 was unsure if there should be assessments, physician's orders, and consents for these devices. V2 confirmed R5's care plan should include the body pillow and safety belt.

On 3/15/25 at 2:06 PM the facility's restraint policies were reviewed with V1 Administrator and V2. Both confirmed the body pillow and safety belt are considered restraints for R5, and that these devices had not been considered restraints

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prior to today. V1 and V2 confirmed there should be physician's orders and quarterly assessments for these restraints. They confirmed there are no orders for these restraints, no assessment for the body pillow, and the last documented safety belt assessment was in June 2024. V2 stated staff should release the safety belt to provide cares. At 2:30 PM V1 confirmed there are no documented consents for these restraints.

On 3/15/25 at 2:19 PM V5 MDS/Care Plan Coordinator stated V5 considered R5's safety belt as an enabler and not as a restraint since it allows R5 to sit in a wheelchair. V5 confirmed R5 is unable to remove the safety belt herself.

(B)

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300.696a)
300.696b)
300.696d)14)

Section 300.696 Infection Prevention and Control

a) A facility shall have an infection prevention and control program for the surveillance, investigation, prevention, and control of healthcare-associated infections and other infectious diseases. The program shall be under the management of the facility ' s infection preventionist who is qualified through education, training, experience, or certification in infection prevention and control.
b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of

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personal protective equipment as provided in the Centers for Disease Control and Prevention ' s Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration ' s Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code.
d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340):
14) Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of Novel or Targeted Multidrug-resistant Organisms (MDROs)

These requirements are NOT MET as evidenced by:

Based on observation, interview, and record review the facility failed to implement enhanced barrier precautions (EBP) for one (R5) of two residents reviewed for EBP in the sample list of 14.

Findings include:

The facility's Enhanced Barrier Precautions policy dated 7/13/23 documents EBP should be used for residents with open wounds or indwelling medical devices and when contact precautions do not apply. This policy documents EBP requires the use of gown and gloves during high-contact resident care when multidrug resistant organisms

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may be transferred to staff hands and clothing, and to ensure gowns are available where the high-contact resident care activities may be required. The high-contact care activities include changing briefs or toileting.

R5's Physician Order dated 1/30/25 documents to maintain enhanced barrier precautions due to percutaneous endoscopic gastrostomy (PEG) tube.

On 3/15/25 during intermittent observations between 8:18 AM and 10:22 AM R5 was lying in bed with feeding infusing via PEG tube. There was a sign posted on R5's room door that indicated EBP to be used for high-contact care activities. There was no cart containing gowns located directly inside or outside of R5's room.

On 3/15/25 at 12:13 PM V10 Certified Nursing Assistant was in R5's room providing R5's incontinence cares. V10 was not wearing a gown during R5's care. V10 stated V10 thought the EBP sign on R5's doorway was for R5's room mate and not R5. V10 confirmed V10 has not been wearing a gown during R5's high-contact cares.

On 3/15/25 at 2:06 PM V1 Administrator confirmed a gown should be worn during R5's high-contact cares as part of EBP. V1 stated a cart containing gowns was just placed near R5's room door to prompt staff before entering R5's room.

(B)

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300.1010g)4)

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S9999	Continued From page 12 300.1010 Medical Care Policies g) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following: 4) Orders from the physician regarding weighting of the resident, and the frequency of such weighing, if ordered. This Requirement is NOT MET as evidenced by: Based on interview and record review the facility failed to follow the physician's order by not notifying the physician upon a weight change for R1. R1 is one of one residents reviewed for notification of physician for weight changes. Findings include: Electronic Medical Record (EMR) dated 1/20/25 documents in the discharge orders for R1 to be admitted to the facility with the following orders on 1/20/25. DISCHARGE INSTRUCTIONS Weigh yourself everyday using the same scale, call PCP for: - any weight gain of 2 lbs over a 24 hr period of time - 5 lbs or greater weight gain in 1 wk - increasing shortness of breath, or swelling in legs, abdomen as you may be retaining fluid Observe low salt diet, keep sodium intake to 1600mg a day Check blood pressure 3x a day, log results of BP and daily weight and bring to PCP (Primary Care Physician) for review.	S9999		

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The Treatment Administration Record (TAR) for R1 dated January 2025 documents the following: Daily weight: if gains 2 pounds in 24 hours or 5 pounds in a week or signs of fluid overload and/or edema give PRN Lasix one time a day. The TAR documents R1 was admitted on 1/20/25, no weight is documented only a nurses initials. This continues until 1/24/25 where R1's weight is documented at 115.2 pounds. On 1/26/25 R1 weight shows 118.4 pounds which is 2.2 pounds increase in 24 hours and R1's EMR does not show where the facility contacted R1's physician about the weight increase. No documentation is available the physician had been contacted at all.

The TAR for the month of February 2025 documents how 6 days were missed in obtaining R1's weight. The TAR for the month of March documents 11 days were R1's weight is not recorded. No documentation was found in regards to notifying the physician or the nurse practitioner about R1 weight gain.

Interview with V1, Administrator on 3/16/25 at 1:30 PM " I was not able to find any documentation about the doctor being notified at all in R1's chart. Looks like the nurses did not contact the doctor." V2, DON (Director of Nurses) stated on 3/15/25 at 3:30 pm " Yes the nurses should of marked down the daily weight of R1 in the chart, and if there was a discrepancy nurses should of contacted me and we would of re-weighed R1."

The facility policy titled "Resident Weight Monitoring" revision date 09/08 documents the following information:
under section titled "Procedure:" #5 states "If there is an actural significant weight change, the

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resident, family/guardian, physician and dietitian are notified. The date of notification for physician and family/guardian is documented on the "Report of Monthly Weight Form." This form was not available for R1.

(B)

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300.1060a)
300.1060b)
300.1060c)
300.1060d)
300.1060e)

Section 300.1060 Vaccinations

a) A facility shall annually administer or arrange for administration of a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year or as soon as practicable if vaccine supplies are not available before November 1. Residents admitted after November 30, during the flu season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of the admission, unless the vaccine is medically contraindicated or the resident has refused the vaccine. (Section 2-213(a) of the Act)

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b) A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, arranged, refused or medically contraindicated. (Section 2-213(a) of the Act)
c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213(b) of the Act)
d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213(b) of the Act)
e) A facility shall distribute educational information provided by the Department on all vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf), including, but not limited to the risks associated with shingles and how to protect oneself against the varicella-zoster virus. The facility shall provide the information to each resident who requests the information and each newly admitted resident. The facility may distribute the information to residents electronically. (Section 2-213(e) of the Act)

These requirements are NOT MET as evidenced by:

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S9999	Continued From page 16 Based on interview and record review the facility failed to offer influenza, pneumococcal and COVID-19 immunizations and maintain documentation of immunizations for four (R1, R2, R4, R5) of five residents reviewed for immunizations in the sample list of 14. Findings include: The Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccine Timing for Adults dated 3/15/23 documents for adults age 65 and older with no prior pneumococcal immunizations give PCV20 (pneumococcal Conjugate Vaccine) or PCV15 followed by PPSV23 a year later, and for those who had PCV13 and PPSV23 (Pneumococcal Polysaccharide Vaccine) give at or over age 65 give PCV20 at least five years later. The facility's Immunization of Residents policy dated 5/6/21 documents the following: The facility will offer immunizations to aid in the prevention of infectious diseases unless medically contraindicated. Verify the date of last vaccination, obtain proof of previous COVID-19, Pneumococcal and Influenza vaccinations and obtain concsent to administer the vaccinations. Offer the COVID-19 vaccine within 14 days of admission, the Pneumococcal vaccination within 30 days of admission, and the Influenza vaccination annually and on admission between October 1st through March 31st. Immunizations should be documented on the resident's Medication Administration Record and on the Immunization Record. This policy documents to follow an algorithm to determine if PCV13 or PPSV23 is indicated. This policy has not been updated to include the 2023 CDC guidance	S9999		

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regarding pneumococcal vaccinations.

1.) R5's Minimum Data Set (MDS) dated 1/5/25 documents R5 is not up to date on COVID-19 immunizations and R5 did not receive this year's influenza vaccine which was not due to any of the following: received outside of the facility, not eligible, offered and declined, not offered, or inability to obtain the vaccine.

R5's Adult Vaccination Consent Form dated 9/4/24 and signed by V13 (R5's Guardian), documents V13 consented for the administration of the influenza and COVID-19 vaccines.

R5's medical record does not document immunizations for influenza and COVID-19 for 2024-2025. R5's active immunization record documents R5 last received a COVID-19 booster and influenza vaccines in October 2023.

The resident vaccine clinic dated 10/22/24 does not list R5 as being offered or receiving the COVID-19 vaccine or influenza vaccine.

2.) R4's MDS dated 1/8/25 documents R4 is not up to date on COVID-19 immunizations, R4 did not receive this year's influenza vaccine and the vaccine was not offered.

R4's ongoing census documents R4 admitted to the facility on 11/29/24. R4's active immunization record does not document any immunization history or status.

3.) R2's ongoing census documents R2 admitted to the facility on 10/10/24 and is over age 65. R2's active immunization record documents Pneumovax 23 was given on 7/2/18, Prevnar 13 was given on 4/11/17, and does not document

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any COVID-19 immunizations. There are no other recorded pneumococcal vaccinations.

R2's MDS dated 1/10/25 documents R2 is not up to date on COVID-19 immunizations and inaccurately documents R2 as being up to date with pneumococcal immunizations.

4.) R1's ongoing census documents R1 admitted to the facility on 1/20/25 and is over age 65. R1's active diagnoses list includes Congestive Heart Failure. R1's active immunizations record documents PCV7 was given on 4/27/18. There are no COVID-19 immunizations and no other pneumococcal immunizations recorded.

R1's MDS dated 1/27/25 documents documents R1 is not up to date with COVID-19 immunizations and inaccurately documents R1 as being up to date with pneumococcal vaccinations.

On 3/15/25 at 11:13 AM V5 MDS/Care Plan Coordinator/Infection Preventionist stated the facility had a COVID-19 and influenza immunization clinic in October 2024. V5 stated the COVID-19 immunization has not been offered to any residents after that clinic. V5 stated R4 and R5 were offered the influenza vaccine as part of the clinic, but the vaccine was not given due to their insurance not covering the cost. V5 confirmed R1 and R2 were not offered a pneumococcal vaccine after admission.

On 3/15/25 between 12:25 PM and 12:39 PM V1 Administrator stated the facility should have offered COVID-19 immunization to residents who admitted after the COVID-19 clinic and was unsure who is responsible for implementing this. V1 confirmed the accuracy of R1's, R2's, R4's, and R5's immunization records. V1 confirmed R5

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did not receive the COVID-19 vaccine during the clinic on 10/22/24. V1 confirmed there are no documented consents for COVID-19, pneumococcal or influenza immunizations for R1, R2, and R5.

On 3/16/25 at 2:00 PM V1 confirmed the facility's policy had not been updated since 2021 and does not include the current CDC guidance for pneumococcal vaccinations.

(B)

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300.1210a)
300.1210b)4)
300.1210d)4)A)B)
Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest

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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. Restorative measures shall include, at a minimum, the following procedures:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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:

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary

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for satisfactory personal hygiene.

These requirements not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide showers to (R2) as scheduled and implement gastrostomy tube interventions and dietitian recommendations for (R5). R2 is one of three residents reviewed for showers, and R5 is one of one reviewed for gastrostomy tubes in the sample list of 14.

1.R2's Facility Census documents R2 was admitted to the facility on 10/10/24 and has the following medical diagnoses; cerebral Palsy, Morbid (Severe) Obesity, Muscle Wasting and Atrophy, Chronic Pain Syndrome, Multiple Fractures of Ribs, Abnormal Posture, Reduced Mobility and Need for Assistance with Personal Care.

R2's Minimum Data Set (MDS) dated 1/10/25 documents R2's Brief Interview for Mental Status (BIMS) score 15, cognitively intact and is dependent of staff for assistance with Activities of Daily Living (ADL).

R2's Care Plan dated 10/25/24 documents R2 Dependent for ADLs-Unable to assist/Assists only minimally. Further decline in ability/participation likely due to lack of motivation. R2 will allow Certified Nursing Assistant to perform ADLs without resistance through next review.
Intervention: Provide bathing, hygiene, dressing and grooming.
The facility's shower schedule documents R2's showers are scheduled twice per week.

R2's February and March 2025 shower sheets provided by V1 Administrator documents R2 has

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not received scheduled showers on 2/14/25, 2/23/25, 2/28/25, 3/1/25, 3/5/25, 3/12/25 and 3/15/25.

Facilities Bath/Shower Policy dated 1/2028 documents: Policy: To ensure adequate hygiene needs are met. A bath/shower is scheduled for all residents in the facility at least weekly.

On 3/16/25 at 10:00am R2 stated that R2 does not receive two showers a week. R2 stated that R2 doesn't even get bed baths.
On 3/16/25 at 9:00am V10 Certified Nursing Assistant stated all residents are scheduled for 2 showers a week. V10 stated if the resident refuses, V10 will come back a little later and ask again. V10 state is the resident still refuses, V10 will notify the nurse who will come talk to the resident. V10 stated if the resident still refuses a bed bath is offered. V10 stated, whether the resident gets a shower or refuses, it should be documented in the resident's chart. V10 stated if its not documented, the resident didn't get it. V10 acknowledged that R2 was not receiving two showers a week, and hasn't had a shower in March 2025.

On 3/16/25 at 9:25am V1 Administrator stated that all residents are scheduled for 2 showers a week and should be getting them. V1 stated that no showers were given on 3/15/25 as scheduled. V1 stated that all showers should be documented in the residents chart, as given or refused. V1 stated if a resident is refusing a bed bath should be offered and the nurse should be notified. V1 confirmed that R2 did not receive scheduled showers on 2/14/25, 3/1/25, 3/5/25, 3/12/25 and 3/15/25.

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2.) R5's Minimum Data Set (MDS) dated 1/3/25 documents R5 has severe cognitive impairment and has a significant weight loss within the last six months that was not physician prescribed.

R5's Care Plan dated 10/24/24 documents R5 receives nutrition via gastrostomy tube and includes interventions to elevate the head of bed 45 degrees during gastrostomy tube feedings and for the dietitian to review and make recommendations as needed.

R5's Dietary Note dated 1/13/25 documents R5's weight as 72.4 pounds (pounds). R5's Dietary Note dated 2/20/25 and recorded by V12 Registered Dietitian, documents: R5's weight as 72.4 pounds and 14.1 body mass index (underwent). R5 consumes nothing by mouth and currently receives Jevity 1.5 calorie feeding at 50 milliliters per hour continuously. R5 has the potential for weigh changes and recommends to continue current feeding and obtain new weight with weekly weights to follow.

R5's ongoing weight log, as of 3/15/25, documents R5's last recorded weight was 72.4 pounds on 12/18/24. R5's electronic medical record (EMR) does not document an order for weekly weights or any weights after 12/18/24.

On 3/15/25 at 10:27 AM V4 Registered Nurse stated weights should be documented under the weight section of the resident's EMR. V4 confirmed the weight on 12/18/24 was the last recorded weight in R5's EMR. V4 located a clipboard on the wall by the nurse's station that contained weights. R5's weight is listed as 72.3 pounds on the week of 2/24/25-3/2/25. V4 confirmed there were no other documented weights and stated V4 was unsure where

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additional weight logs were kept.

On 3/15/25 at 11:00 AM V1 Administrator stated staff are looking for additional weight documentation for R5 and V1 will have staff obtain R5's weight today.

On 3/15/25 at 12:13 PM V10 Certified Nursing Assistant (CNA) was in R5's room providing R5's incontinence cares. R5's feeding was infusing, and the head of the bed was flat. The head of the bed remained flat after V10 finished R5's cares and left the room. V10 was called back to R5's room and asked about the positioning of the head of the bed. V10 confirmed the head of the bed was not elevated. V10 stated the head of the bed should be elevated.
On 3/15/25 at 1:05 PM V8 and V9 CNAs entered R5's room and obtained R5's weight via full mechanical lift. R5's weight was 80.8 pounds.

On 3/15/25 at 1:40 PM V5 MDS/Care Plan Coordinator stated all of R5's weights are now uploaded into R5's EMR.

On 3/15/25 at 1:27 PM V2 Director of Nursing stated if the resident is supposed to have weekly weights there should be an order that prompts to record on the Medication Administration Record. V2 confirmed V12's recommendation for R5's weekly weights should have been implemented.

R5's updated weight log, as of 3/16/25, documents R5 weighed 82.5 pounds on 1/17/25, 72.3 pounds on 2/24/25, and 80.8 pounds on 3/15/25.

The Facility's Enteral Feedings policy dated February 2008 documents the dietitian will monitor tube feeding orders and make

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S9999	Continued From page 25 recommendations as appropriate based on the resident's needs. Weights will be monitored at least monthly or more often if unstable and significant weight fluctuations should be reported to the physician and dietitian to evaluate the appropriateness of the feeding. The head of the bed will be a minimum of 30-40 degrees during feedings. (B)	S9999		