Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Illinois Veterans' Home – Manteno

Location: One Veterans Drive, Manteno, IL 60905

Onsite / Virtual: Onsite

Dates of Survey: 10/17/23 – 10/20/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 304

Census on First Day of Survey: 202

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from October 17, 2023, through October 20, 2023, at the Illinois Veterans Home – Manteno. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on record review and interview, the facility failed to ensure, upon the death of a resident with personal funds deposited with the facility, to convey those funds within 90 calendar days and supply a final accounting of those funds, to the appropriate individual or entity for two (2) of five (5) residents sampled (Residents #26 and #27). The findings include: Record review of the facility policy on "Conveyance of Funds Upon Death of a Member," dated 7/23, revealed: "It is the policy of the [facility] to process and return any person funds of a deceased member to the individual or probate jurisdiction administering the member's estate as expeditiously as possible." The record further revealed: "I. The [Administrative Staff A's] office upon notification of a member's death: a. Send out a Small Estate Affidavit (SEA) along with a request for a certified copy of the death certificate to the family or

	responsible party by certified mail. Note: The SEA signatures must be notarized. b. The SEA cannot be modified after it has been signed and notarized. c. Upon the return of these documents to the [Administrative Staff A's] Office, they are forwarded to the [Administrative Staff B] in the [LOCATION], along with a copy of the trust fund account, death certificate, and voucher payable request form. II. The [LOCATION] will complete a request for a check(s) to be cut and mailed to the party(s) listed on the completed SEA, finalizing the distribution. II. Within 30 days of receiving the properly completed SEA and death certificate, the member's funds, and a final accounting of those funds, [the facility] will release the funds to the individual or probate jurisdiction administering the member's estate." Record review of the facility's "Home and Resident Contract between Resident and Facility," revealed: "upon a resident's discharge, or death, [their] account shall be closed and a final accounting made. Any arrearage due and owing the facility by the resident at the time of discharge, whether voluntary or involuntary, is payable in full immediately. Maintenance charges unpaid upon death of a resident or former resident shall constitute a claim against that resident estate. The Department shall file a claim for unpaid maintenance charges against the estate in accordance with procedures prescribed by the Uncollected State Clams Act and Illinois State Collection Act of 1986." Record review revealed Resident #26 expired in the hospital on [DATE]. Resident #26's Power of Attorney (POA)/Responsible Party was mailed a letter from the facility, on [DATE], indicating the resident had a balance of $1,212.11 in the trust fund and it could not be released: "until [the facility had] been provided with a certified death certificate and either a signed copy of the Last Will and Testament or a notarized Small Estate Affidavit." Further review of the record revealed, on [DATE], a letter was sent to the [LOCATION] by Administrative Staff A's office, stating they had received the death certificate and SEA. However, there was no documentation of a check written to the estate of Resident #26 or the POA/Responsible Party. Resident #27 expired in the facility on [DATE]. Resident #27's POA/Responsible Party was mailed a letter from the facility, on [DATE], indicating the resident had a balance of $106,652.11 in the trust fund and it could not be released: "until [the facility had] been provided with a certified death certificate." Further review of the record revealed, on [DATE], a letter was sent to the [LOCATION] by Administrative Staff A's office stating they had received the death certificate, and a Last Will and Testament was on file. However, there was no documentation of a check written to the estate of Resident #27 or the POA/Responsible Party.

	During an interview, on 10/19/23, at 10:22 a.m., Administrative Staff A reported that when members passed away, the family/POA was sent a letter with condolences, the balance of the resident's trust fund, and information on the documents needed to be turned in before the moneys were released. Administrative Staff A reported the documents required were a death certificate and a SEA or last will and testament. Administrative Staff A reported that when the required documents were received, they filled out a form and turned it into the [LOCATION] to release the funds. Administrative Staff A confirmed Resident #26 expired in the hospital on [DATE], and had a trust fund balance of $1,212.11. Administrative Staff A reported a letter was sent to Resident #26's POA/RP explaining the balance and required documents on [DATE]. Administrative Staff A reported they had received the SEA and death certificate for Resident #26 and sent a letter to release the funds to the [LOCATION] on [DATE]. Administrative Staff A confirmed Resident #26's death certificate was dated [DATE], and the SEA was notarized on [DATE]. Administrative Staff A reported there was no documentation to determine the date when Resident #26's POA/RP delivered this information. Administrative Staff A confirmed that, even though the letter was sent to the [LOCATION] on [DATE], to their knowledge a check still had not been written. In regard to Resident #27, Administrative Staff A confirmed the resident died in house on [DATE], and a letter was mailed to the POA/RP on [DATE]. Administrative Staff A confirmed that, on [DATE], they sent a letter to the [LOCATION] that indicated they had the resident's last will and testament on file and that a death certificate was received and to release the resident's funds. Administrative Staff A reported that the Business Office reported to them that the POA/RP had to get Letters of Office before they could release the funds because the POA/RP was the Estate Executor, but had to go through probate court. Administrative Staff A reported that to their knowledge, the [LOCATION] had not received that back from Resident #27's POA/RP and, as a result, the funds had not been released. Administrative Staff A confirmed the regulation did not state the family member/RP for the deceased veteran had to turn in a death certificate or SEA or last will and testament, but that was their policy. During an interview, on 10/19/23, at 10:27 a.m., Administrative Staff C reported that Resident #26's account had not been paid out, but would be today because Administrative Staff A had received the information from the family members. Administrative Staff C reported Administrative Staff A's office sent a letter to the families and then they waited to receive the paperwork, and then the money could be released to the family. During an interview, on 10/20/23, at 11:12 a.m., Administrative Staff D reported they were told they had to get an official will

	because the will on file for Resident #27 was a copy, and that Resident #27's POA had to go through a court to get Letters of Office before they could write a check to the POA/RP. Administrative Staff D reported from their understanding, Resident #27's POA/RP was working on getting the Letters of Office from the court. However, Administrative Staff D called Resident #27's POA/RP yesterday, and they reported they had the Letters of Office now, but had to get the resident's children's signatures. Administrative Staff D stated they were not sure if they could write a check to the resident's estate. Administrative Staff D said the court needed the Letter of Office to release the estate to the POA/RP. Administrative Staff D reported they were not sure if the will on file for Resident #27 was the original, and the original was needed. Administrative Staff D reported they were not aware of Resident #26 and if the check had been written to their family. Administrative Staff D reported they would look into it. In an email correspondence between the surveyor and the staff, on 10/20/23, at 11:57 a.m., Administrative Staff D responded: "You asked if we can write the check to the estate [of Resident #27] because we are supposed to dispense funds within 90 days after a member expires: • According to my accountant supervisor […], the funds can be released to the estate but [LOCATION] would have to have the Tax Identification Number (TIN) #, W9, identification, an address of where to release it to, and a will or affidavit. [LOCATION] does not deal directly with the families, so we ensure that we are timely from the [LOCATION] side in terms of paperwork. [LOCATION] must wait for the [Administrative Staff A's] office to provide this information because it has to be reported properly. Regarding [Resident #26]: • Fiscal recently received [Resident #26's] paperwork this week from the [Administrative Staff A's] Office, see attached for date stamp. We received the information on [DATE], and the check was written today. Thanks."
§ 51.100 (a) Dignity. Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, and record review, the facility failed to treat a resident with respect and dignity during a lunch meal service, and care for them in a manner and in an environment that promoted maintenance or enhancement of their quality of life for one (1) of 22 residents (Resident #1). A staff member knowingly assisted the resident with eating from a tray that was contaminated by a blanket in the food. The findings include: Record review of the facility policy on "Member Rights," dated July, 2023, revealed: "It is the philosophy and policy of the [facility] to treat all members in the least restrictive and most dignified manner possible."

	Review of Resident #1's medical record revealed they were admitted to the facility on [DATE], with diagnoses which included: Alzheimer's disease, Paroxysmal Atrial Fibrillation, Major Depressive Disorder, Dementia with Severe Mood Disturbance, and Adult Failure to Thrive. Record review of Resident #1's hospice binder revealed a Physician Order, dated [DATE], which indicated, "Diet: Pleasure feed pureed diet with thickened liquids," and, "activity: up as tolerated with full assist. May remain in bed if more comfortable." Observation and interview in the [LOCATION] during the lunch meal on 10/17/23, at 11:42 a.m., to 11:58 a.m., revealed Resident #1 seated in their wheelchair at the table where the residents requiring feeding assistants were seated. Resident #1's lunch tray was opened and placed in front of them, and staff walked away. After two (2) minutes, the resident began sticking their finger into the plate and moving the pureed food around, but not in an attempt to bring the food to their mouth. The resident then began to spill the food on the blanket that was in their lap, and then put the blanket into the food. The surveyor got Certified Nurse Aide A's attention and pointed out Resident #1 actions. Certified Nurse Aide A stated, "Why [do they] have [their] plate? [They] should not have [their] plate because [they need] help being fed." Certified Nurse Aide A moved the plate away from Resident #1 and removed the soiled blanket. Certified Nurse Aide A then went and retrieved wipes and cleaned Resident #1's hands. Certified Nurse Aide A then sat in the chair next to Resident #1 and proceeded to feed the resident out of the plate that had the resident's fingers and blanket in it a few minutes prior. When asked, Certified Nurse Aide A confirmed they were feeding the resident from the same contaminated plate. Certified Nurse Aide A confirmed they could have called the [LOCATION] to get the resident another plate, but they did not. In an interview with Administrative Staff E, on 10/20/23, at 9:38 a.m., they confirmed they had talked with the staff about not sitting Resident #1's tray in front of them until they were ready to feed them. Administrative Staff E confirmed that the practice of leaving the food open to the resident and then feeding it to them after they stuck their blanket into the tray was not right. Administrative Staff E reported that they had reeducated the staff.
§ 51.110 (c) Accuracy of assessments. (1) Coordination— (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals. (ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the	Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) was completed for one (1) of 22 residents (Resident #1) reviewed for MDS assessment accuracy. Resident #1's Discharge Return Anticipated MDS, dated [DATE], did not indicate the resident had a fall with no

assessment. (2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	injuries. Resident #1's Significant Change MDS, dated [DATE], did not indicate the resident had a terminal prognosis. The findings include: Record review of the Centers for Medicare and Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October, 2023, documented: -Under Section J: J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent revealed in Steps for Assessment to: "3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home." The same record revealed under the Coding Instructions for J1900 to: "Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury." - Under Section J1400: Prognosis Steps for Assessment, it revealed: "1. Review the medical record for documentation by the physician that the resident's condition or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness. 2. If the physician states that the resident's life expectancy may be less than 6 months, request that [they] document this in the medical record. Do not code until there is documentation in the medical record. 3. Review the medical record to determine whether the resident is receiving hospice services." The same record revealed under the Coding Instructions for Coding Instructions: "• Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services. • Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services."

	Record Review of Resident #1's medical record revealed they were admitted to the facility on [DATE], with diagnoses which included: Alzheimer's disease, Paroxysmal Atrial Fibrillation, Major Depressive Disorder, Dementia with Severe Mood Disturbance, and Adult Failure to Thrive. Record review of Resident #1's Discharge MDS, dated [DATE], was not coded for the resident having a fall with no injury. Record review of Resident #1's Significant Change MDS, dated [DATE], revealed the resident was assessed as receiving hospice services, but was not coded to have a terminal prognosis of six-month life expectancy. Record review of Resident #1's comprehensive Care Plan, reviewed on [DATE], revealed the following focus areas: - "[Resident #1] is a high risk for falls r/t Confusion, Gait/balance problems. Actual fall [DATE]." - "[Resident #1] has a terminal prognosis [related to] advancing Alzheimer's disease." Review of Resident #1's Progress Notes revealed a Fall Note, dated [DATE], which revealed: "Fall occurred: Date/time of fall: [DATE], 12:55 p.m., Narrative of fall: Staff observed member sitting on the floor. [Passive Range of Motion] noted on all extremities w/o pain. Denies pain at this time." Review of Resident #1's hospice binder revealed an Integrated Plan of Care, dated [DATE], which noted a problem of: "Resident had terminal illness with prognosis of 6 months or less given the normal disease progression." During an interview, on 10/19/23, at 2:58 p.m., Licensed Nurse A confirmed Resident #1's Discharge Return Anticipated MDS, dated [DATE], did not indicate the resident had a fall with no injuries; and the resident's Significant Change MDS, dated [DATE], did not indicate the resident had a terminal prognosis. Licensed Nurse A reported the MDSs were miscoded and not marked by mistake.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care.	Based on observation, interview, record review, review of facility policy, and review of documentation on the Shingrix (Shingles vaccine) website, it was determined the facility failed to ensure that services provided met professional standards for one (1) of 22 sampled residents, Resident #12. Resident #12 was admitted to the facility on [DATE]. The resident's admission orders, dated [DATE], included to administer Shingrix one (1) time only for vaccination. A second dose can't be given until [DATE]. There was no evidence in the resident's clinical record the resident had

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	received the vaccine as ordered by the physician, although a second dose of the vaccine was scheduled to be given on [DATE]. The findings include: Review of facility policy, "Nursing Procedure Nursing Job Routine & Responsibilities," with a reviewed date of 6/23, found documented that: "[Licensed Nurses] have responsibilities that must be accomplished to assure the highest possible quality of life for members of the facility. The following procedure lists responsibilities of all shifts to include # 26. 3-11p duties: Administer and document immunizations as ordered per the Physician." Review of the Shingrix website documentation revealed that: "Shingles is an itchy, painful rash caused by reactivation of the varicella zoster virus, the same virus that causes chicken pox. Shingrix vaccine is proven to be greater than 90% effective in preventing shingles in adults 50 years and older in clinical trials. Shingrix is given as a two (2) dose series, with the second vaccine administered two (2) to six (6) months after the first vaccine. It is important to receive both vaccines." Observation of Resident #12, on 10/18/23, at 9:30 a.m., revealed the resident was sitting in a wheelchair in their room watching TV. The resident was well groomed and dressed appropriately. The resident stated they received dialysis treatment three (3) times per week, and that the facility arranged for transportation to and from the dialysis center. Review of Resident #12's clinical record revealed the resident was admitted to the facility on [DATE], from another nursing facility. The resident had diagnoses that included End Stage Renal Disease (ESRD), Hypertension, Dementia, Parkinson's Disease, Hypotension and Hyperlipidemia. The resident's Admission Physician Orders, dated [DATE], included: "Shingrix Intramuscular Suspension Reconstituted 50 MCG/0.5ML (micrograms/milliliter) (Zoster Vaccine Recombinant Adjuvanted), Inject one (1) application intramuscularly one (1) time for vaccination, [DATE]. Second dose may be administered until [DATE]." Review of the resident's record revealed no evidence the Shingrix vaccine had been administered and/or had been offered to the resident. On 10/19/23, at 11:10 a.m., an interview with Licensed Nurse B revealed they had reviewed Resident #12's record and could not find evidence that the Shingrix vaccine had been administered. They said they had called the pharmacy, and the pharmacy informed them that the Shingrix vaccine had been delivered to the unit on [DATE], and that the Shingrix vaccine had not been returned to the pharmacy. Licensed Nurse B said the resident was scheduled to receive a second vaccine on [DATE], but the

	physician needed to be contacted since the facility could not give the second vaccine because they were not sure if the resident had received the first vaccine as ordered. An interview with Consultant Staff A, on 10/20/23, at 9:05 a.m., revealed the nursing staff needed to contact whoever was on duty on the 3-11 shift, on [DATE], to see if the Shingrix vaccine was given and why it was not documented by the nurse, as the second dose could not be given without evidence of the date the first dose was given. An interview with Administrative Staff E, on 10/20/23, at 9:55 a.m., revealed Administrative Nurse A was currently on medical leave. They said that according to facility policy, it appeared that the 3-11 nurse should have administered the Shingrix vaccine to Resident #12 on [DATE], when the vaccine was delivered to the unit, but there was no evidence in the resident's record the resident was administered the vaccine as ordered.
§ 51.120 (m) (1) Unnecessary drugs (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, and record review, the facility failed to ensure two (2) of five (5) residents (Resident #16 and Resident #13), who were prescribed psychotropic medications, were free from unnecessary drugs; failure to ensure each medication had an adequate indication or diagnoses for use; and failure to ensure the behaviors medications were intended to treat were monitored. This placed these and other residents at risk for unnecessary drugs. The findings include: Review of the facility policy titled, "Psychotropic Medication Use," dated 5/23, indicated psychotropic medications were any drug that affected brain activity associated with mental processes or behaviors, which included antipsychotics, antidepressants, antianxiety, and hypnotics. The policy titled, "Drug Utilization Review Indicators," dated 5/23, indicated monthly medication review of psychotropic medications would occur per OBRA (Omnibus Budget Reconciliation Act) regulations. The policy noted discrepancies were documented under entries titled, "Pharmacy Medication Review," in the progress notes, and a notification email would be sent to the physician and Administrative Nurse A. 1. Resident #16 was admitted to the facility on [DATE], with multiple medical diagnoses which included Dementia. Resident #16 resided in a [LOCATION], which was intended to keep residents who wandered or attempted to leave the facility safe. Throughout the survey observations during waking hours, between 10/17/23, and 10/20/23, it was revealed the resident walked

	independently in and around the unit, attended meals, and engaged in activities. The current Medication Administration Record (MAR) revealed the resident was administered an antipsychotic twice a day for "mood and sleep," and "Melatonin" was prescribed for insomnia, or sleep. Although both medications were prescribed for sleep, the behavior monitors for [DATE] found no monitor for sleep was in place. This left the facility staff without information to determine if either of the medications ordered assisted with sleep. The Pharmacy Medication reviews documented in Resident #16's clinical record, between [DATE] and [DATE], made no mention of the lack of a monitor for sleep, or the administration of an antipsychotic medication for mood and or sleep. 2. Record review of Resident #13's clinical record revealed they were admitted to the facility on [DATE], with multiple medical diagnoses that included Dementia and Insomnia. Resident #13 resided in the [LOCATION]. Throughout the survey, observations of Resident 13 revealed they walked in the unit, attended meals, and engaged in activities. The current MAR, dated [DATE], indicated the resident was administered two (2) medications to assist with sleep: Melatonin, initiated [DATE], and Trazadone, an antidepressant, initiated [DATE]. Although the order indicated the two (2) medications were to be administered for insomnia, there was no evidence a sleep monitor was in place to determine if the medication was an effective treatment for insomnia. The Pharmacy Medication reviews documented in the record, between [DATE], and [DATE], did not identify any discrepancies [i.e., lack of monitoring sleep or the indication (diagnosis) for use of medication]. On 10/20/23, at 10:00 a.m., Consultant Staff A was interviewed about the facility policies for medication reviews. When asked about what type of discrepancies were reported to the administrative staff, Consultant Staff A stated medication errors. When asked about ensuring medications had an adequate indication, they acknowledged some of the diagnoses associated with the use of antipsychotic medication needed to be updated, and acknowledged the behavior related to the medication should be monitored.
§ 51.120 (m) (2) Antipsychotic Drugs. Based on a comprehensive assessment	Based on observation, interview and record review the facility failed to ensure two (2) of four (4) sampled residents (Resident #14

of a resident, the facility management must ensure that— (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	and Resident #16) administered antipsychotic medications had gradual dose reductions of the medication to ensure the lowest effective dose was in place. Failure to implement and document gradual dose reductions left residents at risk for receiving unnecessary drugs, and potentially having adverse side effects associated with their use. The findings include: The facility policy titled, "Psychotropic Medication Use," dated 5/23, stated gradual dose reductions should be attempted twice within the first year, in two (2) separate quarters, at least two (2) months apart, and then annually thereafter, unless clinically contraindicated. 1. Review of Resident #14's clinical record revealed the resident was admitted to the facility on [DATE], with multiple medical diagnoses that included Dementia without Behavioral Disturbances. The resident resided in the [LOCATION]. The current medication orders, dated [DATE], indicated the resident was administered an antipsychotic (AP) medication and an antianxiety (AA) medication. The Medication Administration Record (MAR) documented the same dose of the AP had been administered for Depression/Dementia since [DATE]. Throughout the survey, observations between [DATE], and [DATE], revealed Resident #14 wandered in and around the unit, and at times slept during waking hours. The resident was dependent on staff for all activities of daily living. The resident was observed with slight leg and arm tremors, which became more visible at times. Review of documentation of behavior monitors for [DATE], [DATE], and [DATE], indicated the resident had sporadic behaviors which included wandering and/or occasionally resisting care. The Pharmacy Reviews completed between [DATE], and [DATE], did not identify any concerns with the administration of the AP medication for depression/dementia. A dose reduction of the AP medication was completed on [DATE], which appeared to be successful. However, there was no evidence that any further Graduated Dose Reductions (GDR) had been recommended or attempted. On 10/18/23, at 3:20 p.m., Administrative Nurse B, was interviewed about Resident #14's behavior. Administrative Nurse B stated the resident did not have any behavioral issues and explained the resident at times had arm and leg tremors. On 10/20/23, at 10:00 a.m., during an interview Consultant Staff A stated they were aware of Resident #14's tremors, and stated they could be an adverse side effect of the current medications

	administered. When asked if there was any documentation in the pharmacy notes about gradual dose reductions for Resident #14, the staff was not able to find any. 2. Record review of Resident #16's clinical record revealed the resident was admitted to the facility on [DATE], with multiple medical diagnoses that included Dementia. Resident #16 resided in [LOCATION], intended to keep residents who wandered safe. The current MAR revealed the resident was administered an AP medication twice a day for "mood and sleep." The Medication administration record showed the last dose adjustments occurred on [DATE]. There was no evidence of any attempted dose reduction of the AP occurred since [DATE]. The Pharmacy Reviews between [DATE], and [DATE], noted on [DATE], the resident had falls and stated the AP medication could have contributed to an increased risk of falls, but made no recommendation to reduce the medication. In addition, an entry dated [DATE], noted the AP medication increased the risk of death. The last dose adjustments occurred on [DATE], and no recommendation for a GDR was made. On 10/20/23, at 10:00 a.m., during an interview, Consultant Staff A could not locate any documentation in the pharmacy notes about gradual dose reductions for Resident #16.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on observation, interview, and record review, the facility failed to ensure foods were stored, prepared, and distributed under sanitary conditions. Failure to ensure food preparation and storage units were maintained in a sanitary condition increased the risk for residents who received foods prepared in the [LOCATION] to experience a food borne illness. The findings include: 1. Failure to ensure supplements were dated to ensure they were consumed prior to the "use by" date recommended by the manufacturer which is typically 14 days. On 10/17/23, during a [LOCATION] tour between 10:00 a.m., and 10:30 a.m., a sheet pan that contained approximately 25 to 30 Health Shakes (nutrition supplement) was observed in one (1) of the reach-in refrigerators, and they had no date which documented when they were taken from the freezer, or a "use by" date (These items were delivered frozen and have no manufacturer's expiration date on the individual cartons.) In an interview with Dietary Staff A, they were asked how staff monitored the "use by" dates on the Health Shakes. They explained the date they were removed from the freezer should be

	documented on the individual cartons. Dietary Staff A then discarded the undated items. 2. Failure to ensure temperatures of the dish washing machine were consistently monitored. Review of the dish machine log revealed that staff was directed to document the wash, rinse, and final rinse cycle temperatures daily for each meal. The log also stated; “ANY TEMPERATURES BELOW RANGE MUST BE IMMEDIATELY REPORTED TO THE [ADMINSTRATIVE STAFF MEMBER] ON DUTY.” The temperature log for 10/23, which was found on a clip board in the dish room, was reviewed. The log showed the temperatures were sporadically documented throughout the month. The data revealed only 43 entries out of the potential 150 entries requested through 10/16/23, had been made. In an interview with Dietary Staff A, they were asked if additional temperature testing equipment was available. They reported they did have the temperature test strips to verify if the display on the temperature gauges was correct. (A test strip that adheres to the surface of a dish and changed color to indicate the temperature reached inside the dish machine.) When asked how often that test was completed, they stated weekly, and said they did not keep documentation of the results. When asked for the monthly temperature log for 9/23, Dietary Staff A went to their office with the surveyor. After looking through a stack of papers, which also appeared to be incomplete temperature logs for the dishwashing machine, they said they could not find it. On 10/17/23, at 3:00 p.m., during a follow-up interview, Dietary Staff A provided the 9/23, dishwasher temperature log which showed no missing data. Dietary Staff A validated that while looking for this log, multiple omissions of data were observed on the other monthly temperature logs. 3. Failure to ensure food preparation equipment was cleaned and sanitized after each use. Review of the undated facility policy titled, “Equipment Cleaning and Sanitation,” revealed under “Procedures,” that food preparation equipment was to be cleaned and sanitized after each use. On 10/17/23, during a tour between 10:00 a.m., and 10:30 a.m., during the initial tour of the [LOCATION], Dietary Staff A was present. The food slicer was observed to be soiled with food

	residue on the blade, blade cover, and base. Dietary Staff A asked the staff present in the food preparation area when it was last used; none of the staff present could recall using it recently. On 10/17/23, between 10:00 a.m., and 10:30 a.m., a large mixer was observed, and a staff member was preparing to use it. The underside of the rotary blade had visible dried batter on it. On 10/18/23, at 12:00 p.m., during a follow up observation in the food production area, two (2) table mounted can openers were observed with food matter dried on the blades. In addition, three (3) bases for blenders were observed with dried food spills and particulate matter on them. 4. Failure to ensure food storage areas were clean and ensure carts used in the [LOCATION] were routinely cleaned and sanitized. The undated facility policy titled, “Equipment Cleaning and Sanitation Procedures,” indicated reach – In coolers were cleaned weekly. This policy did not identify the frequency the carts used in or outside the [LOCATION] would be cleaned. An observation, on 10/17/23, between 10:00 a.m., and 10:30 a.m., revealed a cooler was located adjacent to the tray line. The cooler was waist high and when the lid on top of the unit was opened, visible black colored dirt, debris, and standing water were observed on the bottom. Dietary Staff A reported the unit was used to hold individual milk cartons in milk boxes on the tray line, and explained they were moved back to the walk in after the tray line. An observation, on 10/17/23, between 10:00 a.m., and 10:30 a.m., revealed two (2) reach-in refrigerators near the tray line were soiled with food spills and splashes on the inside, and the seals on the doors were soiled with a black mold and/or mildew-like substance. On observation, on 10/17/23, between 10:00 a.m., and 10:30 a.m., revealed the ice machine door and the interior edge around the ice bin were soiled, and the seal (around the door) had visible mildew and or mold-like substance on it. An observation, on 10/17/23, between 10:00 a.m., and 10;30 a.m., revealed the walk-in refrigerator had two (2) empty metal carts with doors near the entry way, which were soiled inside and out. Dietary Staff A stated they were no longer used for food storage, and said the two (2) carts were just stored there. An observation, on 10/17/23, between 10:00 a.m., and 10:30 a.m., revealed a soiled cart was observed in the [LOCATION] in the

	coffee preparation area. The frame of the cart was observed with a heavy buildup of spills, splashes, dust, and dirt along the bottom frame and shelf.
§ 51.170 (a)-(c) Dental services. A facility must provide or obtain from an outside resource, in accordance with §51.210(h) of this part, routine and emergency dental services to meet the needs of each resident; (b) A facility may charge a resident an additional amount for routine and emergency dental services; and (c) A facility must, if necessary, assist the resident— (1) In making appointments; (2) By arranging for transportation to and from the dental services; and (3) Promptly refer residents with lost or damaged dentures to a dentist. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interviews, record review, and review of facility policy, the facility failed to ensure a resident received assistance in making appointments and arranging for transportation to and from the dentist for one (1) of two (2) residents reviewed for dental services (Resident #3). The findings include: An interview with Administrative Staff E, on 10/19/23, at 9:45 a.m., revealed the facility did not have a policy regarding dental services provided by the facility or assisting residents with finding a dentist, scheduling a dental appointment, and arranging for transportation to and from the dentist's office. Administrative Staff E stated the residents were informed of the facility's practice regarding dental services, and it was identified in their individual contracts. Review of the medical record for Resident #3 revealed an admission date of [DATE]. Diagnoses included [DIAGNOSIS], Anemia, Chronic Kidney Disease, Arteriovenous Fistula, Atherosclerotic Heart Disease (ASHD), Benign Prostatic Hyperplasia (BPH), Amputation of One Lesser Toe, Dependence on Renal Dialysis, End Stage Renal Disease, Hypertension, Gout, Major Depression, Peripheral Vascular Disease, Polyosteoarthritis, Pulmonary Hypertension, Hypercholesterolemia, Thrombocytopenia, Inguinal Hernia, Atrial Fibrillation, Congestive Heart Failure, Glaucoma, Protein-Calorie Malnutrition, and Xeroderma Pigmentosum. Review of the quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of [DATE], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #3 had intact cognition for daily decision making. Review of the Physician Orders for Resident #3 revealed an order dated [DATE]. The order stated for Resident #3 to see the dentist for lower teeth extraction. Review of a Physician's Progress Note, dated [DATE], found noted: "Member asked to see me today regarding problems with [their] teeth. Member has had all of [their] upper teeth pulled and has residual teeth in the anterior portion of the lower jaw. Multiple teeth with dental caries, cracked enamel and gingival swelling. Recommended a referral to dentist for extraction of the remaining teeth and for possible fitting of dentures for the upper and lower jaw if the patient desires."

	Review of the Physician's Progress Note, dated [DATE], noted the plan was to refer to dental services for extraction of remaining mandibular teeth. Review of the Nursing Progress Note, dated [DATE], noted the following: "Member to see [Consultant Staff B], one [1] time only for Lower Teeth Extraction for 60 days. Appointment request sent. [Consultant Staff C] notified" [sic]. Review of all Progress Notes in the medical record of Resident #3 revealed no further notes in regard to a dental appointment was made for Resident #3. A review of a Nursing Progress Note, dated [DATE], at 1:30 p.m., revealed the Power of Attorney (POA) and the physician had a meeting to discuss the health Care Plan for Resident #3. Resident #3, the POA, and the physician agreed to hold off on cardiac surgeries, but approved to move forward with cataract surgeries. Dental services were not documented as discussed during the team meeting. On 10/17/23, at 11:30 a.m., during an interview with Resident #3, they stated that no one had gotten back to let them know when the dental appointment was scheduled. Resident #3 stated, "I want to get my new teeth so I can eat a real pork chop and not that chopped up stuff." On 10/18/23, at 11:10 a.m., during an interview with Consultant Staff D and Consultant Staff C for [LOCATION], they confirmed there was no documentation regarding a dental appointment for Resident #3 since the physician wrote the order on [DATE]. They stated the resident had no funds, and the POA refused to pay a dental bill. They confirmed they had not documented conversations with Resident #3 or their POA. Consultant Staff D and Consultant Staff C for [LOCATION] confirmed there had been no contact with Consultant Staff B to schedule the consultation to have their teeth extracted. They confirmed they had not had a discussion with Administrative Staff E regarding the dental care for Resident #3, or if a payment schedule could have been arranged with the POA. They confirmed Resident #3 had multiple teeth with decay and had not seen Consultant Staff B since their admission to the facility in [DATE]. They acknowledged the referral for a dental consultation had been received on [DATE]. They confirmed there was no documentation of conversations with Resident #3 or their POA regarding dental services.