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M 000	INITIAL COMMENTS On 07/17/2024, Surveyor conducted a standard survey and complaint investigation at ILC Eagle House. Data collection continued through 07/30/2024. The complaint was substantiated. Four deficiencies were identified. Census: 4	M 000		
M 360	88.05(6)(c) HOUSEHOLD PETS-HANDLED PROPERLY Pets shall be kept and handled in a manner which protects the well-being of both residents and pets. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all pets were kept and handled in a manner that protected the well-being of both residents and pets. Findings include: On 07/17/2024, Surveyor interviewed Resident 2. Resident 2 stated s/he had moved to the provider a couple of weeks ago. When asked how things were going, Resident 2 stated his/her main concern was related to a staff member's dog. Resident 2 stated the dog had defecated in front of his/her bedroom door at least 3 or 4 times since admission. Resident 2 stated that on one occasion s/he rolled over the feces with his/her walker. Resident 2 stated s/he was frustrated about it. Resident 2 stated the name of the dog but did not know who the dog belonged too.	M 360		

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

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M 360	Continued From page 1 At approximately 1:15 PM, Surveyor interviewed Licensee A. Licensee A stated Caregiver E was the owner of the dog referenced by Resident 2. Licensee A stated s/he was aware the dog had defecated on the floor and had received 3 complaints about it. Licensee A stated the dog would experience anxiety that contributed to the dog's accidents on the floor. Licensee A stated s//he would address the concerns with Caregiver E. On 07/19/2024, Surveyor received records from Licensee A via email that included the following: Resident 2's service agreement signed and dated by Resident 2 on 06/18/2024. A health certificate from a veterinary clinic identifying Caregiver E's dog as a spayed Pomeranian mix. The dog was up to date on its vaccinations. The provider did not ensure all pets were kept and handled in a manner that protected the well-being of both residents and pets when Caregiver E's dog had defecated in the home multiple times in an approximate one month timeframe.	M 360		
M 444	88.07(2)(b)3 TRANSPORTATION TO MEDICAL Providing, arranging, transporting or accompanying a resident to medical or other appointments as part of the resident's individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide or arrange for	M 444		

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transportation and/or accompany Resident 1 to his/her medical appointments.

Findings include:

On 05/28/2024, the department received a complaint alleging residents were missing medical appointments due to the provider being unable to provide transportation.

The provider is licensed to care for up to 4 residents in the client groups of: physically disabled, emotionally disturbed/mental illness, and developmentally disabled.

On 07/17/2024, at approximately 11:00 AM, Surveyor interviewed Licensee A and Program Director (PD) B. Licensee A stated driving residents was a shared responsibility between staff. Licensee A stated 1 staff was scheduled each shift unless appointments or activities were planned. Licensee A stated there would be double coverage to accommodate appointments and activities. When asked about Resident 1's appointments, Licensee A stated Resident 1 had an overwhelming number of appointments. Licensee A stated a couple of Resident 1's appointments needed to be rescheduled due to staff family emergencies. PD B stated it was often challenging to coordinate appointments for Resident 1 as Resident 1's guardian would often prefer to schedule the appointments around his/her own schedule. PD B stated Resident 1's guardian would often inform staff of a medical appointment via text message the night before an appointment was scheduled.

At approximately 12:35 PM, Surveyor interviewed Caregiver F. When asked if it had ever been challenging for the provider to get residents to

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their appointments, Caregiver F stated it was challenging for him/her in the past. Caregiver F stated that arranging and providing transportation for residents was a lot to manage. Caregiver F stated PD B had stepped in to help with resident transportation needs.

On 07/19/2024, Licensee A provided Resident 1's records via email. Resident 1 was admitted to the facility on 08/10/2023 and was discharged on 06/17/2024. Resident 1 had a legal guardian and the following diagnoses: cognitive dysfunction, high blood pressure, tobacco use disorder, adult failure to thrive, narrowing of spinal canal, cervical disc disease with myelopathy, type 2 diabetes, polyuria likely due to nephrogenic DI from longstanding obstruction, hereditary nephrogenic diabetes insipidus, hypernatremia, condyloma acuminatum of [body part], urinary retention, Foley catheter present, decreased circulation, myelopathy in diseases classified elsewhere, stage 3a chronic kidney disease, diabetic ulcer of right midfoot associated with diabetes mellitus due to underlying condition, limited to breakdown of skin, poor dentition, other chronic pain, dental cavities, developmental disability and bilateral high frequency sensorineural hearing loss.

The individual service plan (ISP), reviewed on 01/11/2024 and updated 07/17/2024, included a personal history section that read, in part, "Scheduling staff and arranging [Resident 1's] appointments is often difficult because [Guardian B] will not consult Supervisors or staff about scheduling appointments as [s/he] wants it to work around [his/her] schedule as a nurse in a different time zone two hours earlier. This often leads to last-minute triple coverage needs or other residents missing appointments, activities

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or work. This has been explained multiple times with [Guardian B] not following through on any compromise ...Around this time [Resident 1] had missed an appointment which was double booked with another resident's cares ..." Under a section titled, "Places, Activities, & Community Organizations," it stated all transportation was provided by staff.

An email in the records had the following subject line, "Follow up update before our meeting Thur [Thursday] 11/2/23 11 am meeting," sent from Licensee A to Resident 1's care team. The email read, in part, "Enclosed is a list of issues and situations that have been addressed. Please inform us if anything is missing or if we should continue discussing or revisiting any of them ...Missed appointments (related to poor management of schedule conflicts by the program supervisor and the importance of staying in touch when appointments are scheduled)."

A medical note, dated 11/21/2023, stated the following: "Labs for [Medical Provider] were completed on 11/9, patient no-showed 2 appointments last week. Appointment is needed to review lab results. Upon talking to Guardian B], facility was responsible to taking patient to the appointments but did not bring [him/her]. Writer has re-booked this with [Provider] supervisor."

Resident 1's history of medical appointments identified s/he missed appointments on 11/15/2023, 11/17/2023 and 05/16/2024.

A policy and procedure regarding members supported by the provider included a section titled, "Member Rights Concerning Activities," and indicated assistance with transportation would be provided to each resident.

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M 444	Continued From page 5 The provider did not provide or arrange transportation for Resident 1's medical appointments, resulting in Resident 1 missing at least 3 scheduled appointments.	M 444		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the health of Resident 1 was monitored, with observations and changes in skin health documented. The provider did not monitor and document changes in Resident 1's right foot wound. Findings include: On 07/19/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 08/10/2023. Resident 1 had a legal guardian and multiple diagnoses, including cognitive dysfunction, type 2 diabetes, decreased circulation, diabetic ulcer of right midfoot associated with diabetes mellitus due to underlying condition and limited to breakdown of skin. A new patient intake form from a wound care center, dated 10/25/2023, identified an Ischemic	M 448		

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ulcer of right foot, unspecified ulcer stage. It stated Resident 1's wound started about 3 months ago. The plan instructed Resident 1 to start Aquacel AG as primary dressing to the right dorsal foot wound.

A wound care center note, dated 12/22/2023, included the following assessment: "Ischemic ulcer of right foot, unspecified ulcer stage (*) - worsening. No evidence of infections. Poor hygiene, minimal blood flow to right foot, tobacco use and patients [sic] refusal of dressing changes all likely contributing." The plan section stated, "Start medi honey and Aquacel to the right foot wound. Change dressing 3 times per week with assistance of group home staff. Reinforced the importance of hygiene and washing the wounds prior to dressing changes. Dressings should be changed minimum 3 times per week regardless of if the patient refuses [his/her] shower." Under history of present illness summary, it read, in part, "Patient is here today with group home supervisor, [Caregiver F.] The patient has been refusing wound cares and showers. Reports dressing and showers occur about every 2 weeks. Current wound treatment plan consists of Aquacel AG. [Caregiver F] reports the patient did not receive supplies via DME (Durable Medical Equipment), this is another reason why the dressings have not been changed frequently. Patient does have [Managed Care Organization (MCO)] services in place, which is where the DME was sent 2 months ago. Measurements of the wound are larger today."

Staff progress notes, dated between 11/01/2023 and 12/21/2023, did not include any information regarding Resident 1's foot ulcer or that it had been worsening. There was no documentation to reflect if the wound was healing or worsening

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following the medical appointment between 12/22/2023 and 01/03/2024. On 01/04/2024, a staff progress note stated Resident 1 "sat in [his/her] room and wattched [sic] tv went outside for smoking had lunch nd [sic] meds back to room and outside had shower foot was re wrapped and cleaned had dinner outside then back to room to watch tv." That note was the first documentation found to reference Resident 1's wound care management and it did not identify if the wound had been healing or worsening.

On 07/23/2024, Surveyor received an email from Licensee A. When asked if any skin assessments were completed for Resident 1, Licensee A stated in the email staff were instructed on Resident 1's wound care and would report to Caregiver F, "if wound would look infected, or appeared bigger, or if there were any other significant changes." Staff would also report to program manager about Resident 1 refusing cares. When asked about any communications between staff and medical providers regarding wound care, Licensee A stated staff would report progress or lack of during appointments.

On 07/30/2024, at 11:00 AM, Surveyor interviewed Licensee A, Program Director (PD) B, and Administrator D. When asked about staff documentation of wound care management and monitoring, Licensee A stated Caregiver F would inform Licensee A and Resident 1's MCO with any changes reported to Caregiver F by staff. Licensee A stated the provider had a nurse from an outside agency come in to assist with Resident 1's wound care but the provider did not have documentation to reflect the nurse's observations or care provided to Resident 1. When asked how often the outside agency nurse would assist with wound care management,

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M 448	Continued From page 8 Licensee A stated that on average, the nurse would visit the home twice monthly depending on Resident 1's needs. Licensee A stated s/he would be requesting documentation from the outside agency nurse to ensure the provider had those records. Licensee A stated staff were responsible for the daily monitoring of the wound and the provider expected staff to be documenting observations and changes in the daily routine logs instead of verbal exchanges between staff members. Licensee A stated the provider would often rely on verbal exchanges and text messages rather than documenting changes in writing. Licensee A stated they did not have enough information in writing. Licensee A stated the provider would be offering more staff training related to communication and staff documentation expectations.	M 448		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an accurate record of all medications administered by the licensee was kept. Resident 1's medication administration	M 466		

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record (MAR) did not include record of all medication administrations.

Findings include:

On 07/19/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the provider on 08/10/2023. Resident 1 had a legal guardian and multiple diagnoses, including cognitive dysfunction, type 2 diabetes, decreased circulation, diabetic ulcer of right midfoot associated with diabetes mellitus due to underlying condition and limited to breakdown of skin.

Staff progress note, dated 03/22/2024, included a wound care update that read, in part, "A new wound started lower side of [his/her] foot near the ankle. The following are the instructions moving forward with [Resident 1] wound cares until further notice. Not less than 3x a week (it can be more): "Cleanse the area with mild soup [sic] and water. Pat dry. Apply Eucerin lotion and or Vaseline to skin around the sores (not in the soars [sic]!). This will help to help the skin moisturized [sic], healthy and help with elasticity so to help prevent future sores. Cut pieces of Aquacel to fit the size of the two wounds. Coat with Medihoney and apply to the wound bed. Cover entire top of the foot and side with a Viva-Paper Towel (This allows for any seepage to be absorbed and with help with the swelling in [his/her] foot) hold in place and wrap with rolled gauze. Change the Viva towel more often than 3 xs per week, with lotion to help with any excessive drainage."

On 03/25/2024, a medication order was written

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for Honey 80% Topical Gel. The order stated, "Apply 1 Drop to skin as directed: Apply 1 drop of medical honey to the right foot wound. Cover with Aquacel. Change dressing 3 times per week."

The MAR for March 2024, April 2024 and May 2024 included the dressing changes 3 times weekly with 3 designated days highlighted during the overnight shift. The MARs read, "Aquacel AG apply to wound 3 times per week." The MARs did not include direction to apply the honey topical gel ordered on 03/25/2024.

The June 2024 MAR showed the honey topical gel and dressing changes started on 03/25/2024 and stated the following, "Medihoney Gel Tube Apply one drop of medical honey to right foot wound, cover with Aquacel. Change dressing continued ...three times weekly."

On 07/30/2024, at 11:00 AM, Surveyor interviewed Licensee A, Program Director (PD) B, and Administrator D. When asked if the provider was aware that the prescribed honey topical gel did not appear on the MAR until June 2024, Licensee A stated the honey topical gel was being applied to Resident 1 but it was not on the MAR until then. Licensee A stated the provider was utilizing a homemade MAR in order to accommodate a staff member with vision impairment as that staff member was having difficulty seeing the pharmacy issued MARs. Licensee A stated that if there was a prescription for the topical gel, it should have been on the MAR. Licensee A stated that after speaking with staff, s/he believed the honey topical gel was not medical grade. PD B stated the honey topical gel did not get transferred to the homemade MAR. PD B stated the provider had gone back to using the pharmacy issued MARs to ensure accuracy

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M 466	Continued From page 11 and consistency with medication orders.	M 466		