STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Loft Rehab & Nursing of Normal		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Broadway Normal, IL 61761	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promote dignity for three (R6, R15, R20) of three residents reviewed for dignity in a sample of 23 residents. This failure resulted in R15 experiencing increased anxiety and becoming upset as V53 was overheard yelling/cussing (using foul language in a loud and derogatory manner) towards staff outside of R15's doorway. R6's Minimum Data Set (MDS) dated [DATE] documents R6 has severe cognitive impairment. R6's Care Plan dated 10/18/2022 documents R6 is at potential risk for abuse due to Dementia. Despite R6's inability to comprehend interview questions, R6 was repeatedly observed independently propelling to and remaining near the nurse's station located by the facility's front door where V53 (Former Administrator), V32 Receptionist, and V41 Business Office Manager offices were located. This observation made R6 have the potential to place R6 at risk to hear when V53 Administrator was allegedly being verbally inappropriate and unprofessional towards staff in the hallway. On 3/23/2026 at 9:45am, R6 was in R6's wheelchair in the room and appeared to be clean and well-groomed. R6 was able to propel self in and out of the room independently. R6 could not fully participate in the interview due to decreased cognitive status. On 3/23/2026 at 11:00AM, R6 was observed sitting in a wheelchair in the hallway at the nurse station by the front door. On 3/24/2026 at 9:30AM, R6 was propelling self in the hallway towards the nurse's station by the front door. On 3/24/2026 at 3:52PM, R6 was observed sitting in a wheelchair in the hallway at the nurse's station by the front door. On 3/25/2026 at 10:42AM, R6 was observed sitting in a wheelchair at the nurse's station by the front door. On 3/30/2026 at 09:07AM, R6 was propelling self in the hallway towards the nurse's station by the front door. On 3/30/2026 at 09:26AM, R6 was observed sitting in a wheelchair at the nurse's station by the front door. On 3/30/2026 at 1:24PM, R6 observed sitting in a wheelchair at the nurse's station by the front door. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 3/30/2026 at 3:56PM, R6 observed sitting in a wheelchair at the nurse's station by the front door. On 3/24/2026 at 1:00PM, V41 Business Office Manager stated V53 Former Administrator had been verbally inappropriate and unprofessional in the hallways towards staff members with residents present in the hallway. V41 stated V41 had heard V53 say cuss words like S*** (expletive) or A** (expletive) loudly towards staff members by the nurse station where R6 usually sits. V41 stated V41 would think R6 heard what V53 said although R6 has impaired cognition. V41 stated V41 did not report it to anyone because the incident was discussed during the morning meeting where V53 was present and aware of the concern. On 3/30/2026 at 9:34AM, V56 Receptionist stated V56 has heard V53 Former Administrator cuss loudly in V53's office. V56 stated V56 was not sure if there was another person in the office with V53. V56 stated that V53 then came out of office appeared angry as V53 loudly yelled and cussed while having a conversation over the phone. V56 stated R6 was in the hallway (closer to the reception area and V53's office) where R6 always sits and could hear V53 cussing and yelling. On 3/30/2026 at 10:12AM, V59 (R6's) family member stated V59 and R6 never discussed anyone being verbally inappropriate toward staff or residents. V59 stated R6 would be very upset if anyone was cussing or yelling around R6. On 3/24/26 at 9:20AM, R15 was lying in bed and stated R15 gets to move back to R15's regular room after being in isolation for Respiratory Syncytial Virus (RSV). R15 was clean and well-groomed. R15 stated R15 had heard V53 Former Administrator on one occasion when staff were bringing the crash cart down the hallway, and equipment was positioned on both sides of the hall. R15 stated that V53 began yelling loudly at staff, saying, This is why all these items should be on one side of the hallway! R15 felt anxious and became upset due to V53's yelling. R15 stated that R15 had already been anxious because of the emergency situation occurring at that time, and V53's yelling increased R15's anxiety. R15 also stated that V53 had cursed at staff members on previous occasions in the hallway, and R15 did not like that. On 3/24/2026 at 8:32AM, V32 Receptionist stated V32 has heard V53 cussing loudly in the hallway. V32 stated V32 does not remember the exact dates, but V32 knows that whenever V53 does not like what V53 sees in the hallway V53 will get mad and cuss at staff members. V32 stated V32 has heard V53 say to staff you all are F***** (expletive) S****** (expletive), why don't you take your head out of your A***** (expletive)! R15's Minimum Data Set (MDS) completed on 3/20/2026 documents R15 is cognitively intact. R15's Care Plan with revision date of 8/15/2025 documents R15 is at risk for altered well-being and/or psychological distress related to history of abuse. On 3/24/2026 at 10:06 AM, R20 stated R20 never heard V53 Administrator cuss or use vulgar words, but R20 knows V53 was not a nice person. R20 stated sometime in February R20 went to V53's office to tell V53 about a missing part on R20's wheelchair. R20 stated V53 got mad and walked out of the office. R20 stated V53 did not even look at R20's wheelchair. R20 stated R20 served in the military for 20 years, and R20 was respected but R20 never felt respected by V53 at that time. R20 stated that R20 felt upset because R20 knew what leadership was supposed to look like, and V53's reaction at that time did not reflect that. R20 stated that R20 felt as though V53 was looking down V53's nose at R20. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 3/24/2026 at 2: 28 PM, V32 Receptionist stated V32 has seen R20 going to V53 Former Administrator's office in the past but V32 never knew what was discussed. R20's Minimum Data Set (MDS) dated [DATE] documents R15 has moderate cognitive impairment. The Facility's Conduct and Behavior Policy with a revised date of 2/11/2025 documents all team members must adhere to accepted professional standards. This includes displaying business conduct and behaviors and always exhibiting high integrity. Examples of conduct and behavior that are considered inappropriate and are prohibited by this company include, but not limited to the following: Using profanity, abusive or suggestive languages or gestures, or any other unprofessional behavior. Conflicts between employees should not be discussed in front of visitors or residents and should always be settled in a calm manner.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to recognize and respond to a change in condition that required immediate intervention for two (R1, R8) of three residents reviewed for quality of care and failed to implement the physician's order for continuous oxygen therapy for one (R8) of three residents reviewed for oxygen in a sample of 23 residents. These failures resulted in R8 experiencing acute respiratory distress and being sent to the emergency department for hypoxia. R8 was diagnosed with Acute Respiratory Failure and Acute Congestive Heart Failure exacerbation.Findings Include:1.On [DATE] at 9:36 AM, R8 was observed lying in bed with oxygen at two (2) liters per minute via nasal cannula. R8 appears frail and opens and closes R8's eyes in response to verbal stimuli but does not answer questions or follow commands. R8's lips were noted to be dry and cracked. R8 did not verbally respond during this interaction. R8's Minimum Data Set (MDS) dated [DATE] documents that R8 has the following active diagnoses: Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease, and Chronic Respiratory Failure with Hypoxia, and Congestive Heart Failure. This MDS documents that R8 has severe cognitive impairment and requires continuous oxygen therapy as well as non-invasive mechanical ventilation. R8's Care Plan dated [DATE] documents that R8 has altered respiratory status and difficulty breathing related to Pulmonary Edema, Sleep Apnea, chronic respiratory failure and COPD with an intervention for staff to monitor R8 for signs and symptoms of respiratory distress and report to medical doctor as needed if R8 has any of the following: increased respirations; decreased pulse oximetry; increased heart rate; restlessness; diaphoresis; headaches; lethargy; confusion; hemoptysis; cough; pleuritic pain; or if observed using accessory muscle; and any skin color changes to blue/grey. An additional intervention for this problem area dated [DATE] documents that R8 is to have oxygen via nasal prongs at 2 liters continuously and that R8 will have no complications related to shortness of breath (SOB) though the review date. R8's Electronic Health Record (EHR) contains a hospital discharge summary documenting that R8 was hospitalized from [DATE]–[DATE] and intubated for acute respiratory failure with hypoxia and acute on chronic diastolic heart failure; discharged back to the facility [DATE]. R8 returned to the facility on [DATE] with a physician's order for continuous Oxygen at 2 liters via nasal cannula. On [DATE] at 11:42 AM, V20 Licensed Practical Nurse (LPN) stated V20 recalls the night of [DATE] when R8 was drowsy and complained of shortness of breath (SOB) with a respiratory rate (RR) of 44. V20 stated V20 administered a nebulizer treatment and rechecked R8's vital signs and notified the oncoming nurse of the resident's condition. R8's Electronic Health Record (EHR) documents the postˆnebulizerˆtreatment respiratory rate on [DATE] at 7:18 AM was 36 breaths per minute. No provider notification is documented at that time. R8's EHR contains a progress note dated [DATE] by V42 LPN and documents that V42 entered R8's room and observed R8 experiencing SOB. This note documents that V42 performed an assessment and R8 was noted to have wheezing with evaluated respirations at 28 breaths per minute. This progress note documents that R8 has a known history of Chronic Obstructive Pulmonary Disease (COPD). V42 documented that she obtained R8's vital signs with the following abnormal findings: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	heart rate (HR) 109 bpm (beats per minute), RR 28 breaths per minute and oxygen saturation 93% on five (5) liters of oxygen via nasal cannula. V42 documents that a nebulizer treatment was administered to R8. V2 documented that R8's vital signs were reassessed post treatment with the following findings: HR 102 bpm, and RR 24 breaths per minute. No provider notification is documented at that time. On [DATE] at 12:36 PM, V42 LPN stated the day prior to R8 being sent to the hospital V42 was the nurse taking care of R8 on the night shift. R8 stated it was around 5:00 AM when V42 went into R8's room to give R8's morning medication when V42 found R8 struggling to breathe. V42 stated V42 asked R8 if R8 was having a hard time breathing and R8 shook R8's head yes. V2 stated V2 works through an agency and was unsure of the facility protocol regarding how to handle a resident experiencing SOB, so V2 asked the registered nurse (RN) working the floor and the RN told her to give the resident breathing treatment and pass along to the day shift. On [DATE] at 11:07 AM, V47 RN stated R8 had been in and out of the hospital recently, so V47 had been monitoring R8's vital signs closely during the night shift. V47 stated that on the night prior to R8's admission to the hospital on [DATE], V47 observed that R8's respirations were fast and shallow, but R8's other vital signs appeared stable, so V47 was not concerned. V47 stated that when V47 assessed R8's respirations and obtained a respiratory rate of 31, V47 was not concerned because he did not notice any dramatic change from R8's usual presentation. On [DATE] at 4:14 PM, V51 RN for V64 Nephrologist stated R8 had an appointment with V64 on [DATE] and that according to V64's progress notes from this visit it documents that R8 presented to the office in acute respiratory failure 911 was called and R8 was sent to the emergency department for further evaluation. On [DATE] at 10:07 AM, V52 Transport Driver stated that on [DATE], when V52 transported R8 to V64's office, R8 did not appear to be doing well. V52 stated that R8 was breathing fast, and R8's breathing became worse during the drive to the clinic. V52 reported that V52 was concerned about R8's condition, and upon arrival at the appointment, V52 informed the receptionist that R8 was not doing well. V52 was unsure if R8 was wearing oxygen. On [DATE] at 12:04 PM, V38 Assistant Director of Nursing (ADON) stated that a floor nurse (unsure of name) informed V38 that R8 had been at a routinely scheduled appointment, and that the doctor sent R8 to the emergency room because R8 was lethargic. V38 stated that R8 had been in and out of the hospital recently for Congestive Heart Failure exacerbations. V38 stated that the nurse should have called the physician or sent R8 out with a respiratory rate of 44 breaths per minute and complaints of shortness of breath. V38 stated a respiratory rate of 44 breaths per minute is a significant clinical finding. On [DATE] at 3:34 PM, V51 the RN for V64 (Nephrologist) called back to report that V51 had spoken with V64, who was currently on vacation. V51 stated that V64 confirmed R8 was only arousable to verbal stimuli during R8's appointment on [DATE]. V51 also stated that V64 told him that R8 had been slumped in R8's wheelchair, R8's respirations were fast and shallow, and R8 was not wearing oxygen at the time of the appointment. On [DATE] at 9:05 AM, V61 Nurse Practitioner (NP) stated R8 had been hospitalized in February 2026 for Congestive Heart Failure, Respiratory Failure, and COPD, and that R8 was intubated during that hospitalization. V61 stated that if V20 documented R8's respirations correctly, a respiratory rate of 44 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	was much too fast, and one of the providers should have been notified immediately. V61 also stated that R8 should not have been sent out of the facility without oxygen on [DATE], especially considering her recent hospitalizations and diagnoses. V61 stated that because there was an active physician's order for continuous oxygen, R8 should have been wearing oxygen to prevent oxygen saturation levels from dropping below 90%, which may lead to hypoxia, shortness of breath, and fast, shallow breathing. An Emergency Department Physician Note dated [DATE] at 1:53 PM documented that R8 presented to the emergency department with shortness of breath, had an oxygen saturation of 86 percent and was hypoxic upon arrival. The note documented that R8 was diagnosed with Acute Respiratory Failure and a Congestive Heart Failure Exacerbation, was placed on BiPAP, and was admitted to the hospital. 2. R1's Electronic Health Record (EHR) documents that R1 was admitted to the facility on [DATE] for rehabilitation after a fall at R1's assisted living facility that resulted in a left femur fracture. R1's Minimum Data Set (MDS) dated [DATE] documents that R1 requires partial to moderate assistance with transfers and is independent with feeding. This MDS also documents that R1 is cognitively intact. On [DATE] at 9:14 AM, V67 Certified Nurse Assistant (CNA) stated V67 cared for R1 on the night of [DATE] and that R1 was at baseline that night. V67 stated R1 was alert and able to voice R1's needs. V67 stated R1 slept through the night and only woke up during rounds. V67 stated R1 was not in any distress and did not complain of any discomfort that night. On [DATE] at 9:20 AM, V68 Registered Nurse (RN) stated V68 was the nurse who cared for R1 on the day prior to R1's passing on [DATE]. V68 stated that V68 was familiar with R1, having cared for R1 on previous occasions. V68 stated that R1 was stable throughout that day on [DATE]. V68 stated V68 was very surprised the next time V68 returned to work and learned that R1 had passed away. V68 further stated that CNAs are responsible for obtaining residents' vital signs and that V68's role is to document the vital signs provided to her. V68 stated that V68 was unaware that the vital signs documented on [DATE] and [DATE] were the exact same readings both days (Blood Pressure 133/52, Pulse 61). On [DATE] at 8:44 AM, V66 CNA stated that V66 was very familiar with R1 and had been assigned to R1 the night prior to R1's passing on [DATE]. V66 reported that V66 assisted R1 to bed that evening and recalled having a pleasant conversation with R1 as V66 helped R1 get ready. V66 stated that nothing unusual occurred during the shift and that R1 appeared to be at R1's baseline and comfortable when R1 was put to bed. V66 added that V66 was completely surprised when V66 returned to work the following evening and was informed that R1 had passed away. R1's EHR documents that on [DATE] R1 had multiple indicators of a change in condition. R1's EHR documents that on [DATE] at 07:08 AM, R1's blood pressure was obtained with a reading of 98/45 with a pulse of 61 and documented that R1's blood pressure was taken in the left arm while R1 was lying in bed. R1's Medication Administration Record (MAR) dated [DATE] at 7:07 AM documents that R1's blood pressure was 98/45. This MAR documents that V23 held R1's Metoprolol 100 milligrams (mg). R1's physician order includes Metoprolol parameters to hold if Systolic Blood Pressure is less than 120 or (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	heartrate less than 60 beats per minutes. This MAR also documents that V23 held R1's Adolophine 10mg, which had no parameters, but was held and there was no documentation that the physician had been notified that this medication was held. R1's EHR did not include any documentation showing there was any follow-up assessment, monitoring, or notification to R1's doctor regarding R1's hypotensive episode. R1's EHR also showed no Certified Nursing Assistant (CNA) documentation on [DATE] and [DATE] regarding R1's meal consumption. R1's EHR does not show that any skilled assessments or nursing progress notes were completed for R1 on [DATE] and [DATE]. Last skilled documentation on record was [DATE]. R1's EHR documents that R1 refused breakfast at 8:35 AM on [DATE], and this refusal was recorded on the Certified Nursing Assistant (CNA) eating task in the EHR by V60 CNA. R1 experienced a large, loose incontinent bowel movement at 9:09 AM on [DATE], as documented by V60 CNA on the CNA Bowel and Bladder record in R1's EHR. On [DATE] at 10:17AM, V60 CNA stated R1 was pale, lethargic, weak, and refused breakfast on the morning of [DATE] and that R1 complained of not feeling well. V60 CNA stated V60 reported these findings to V23 Licensed Practical Nurse (LPN) at approximately 9:09 AM but stated V60 did not observe any further follow-up to R1's condition after V60 reported it to V23. On [DATE] at 10:00 AM, V62 Nurse Practitioner (NP) stated on [DATE] at 10:12 AM, V62 assessed R1 and noticed R1 was pale, weak, had a dry mouth, and exhibited decreased alertness compared to baseline. V62 stated V62 immediately reported this to V23 and told V23 that R1 was not feeling well and requested nausea medication. V62 stated V62 then called V61 NP and reported V62's concerns related to R1's change in condition. On [DATE] at 9:14 AM, V23 LPN, confirmed that V23 was aware of R1's low blood pressure and that R1 was ill on the day of R1's passing. V23 stated V23 did not physically assess R1 prior to going to lunch at 11:01 AM on [DATE], and instead only visually observed R1 from outside the room because R1 was sleeping and V23 didn't want to bother her (R1). V23 stated V23 did not notify the provider regarding R1's condition, stating that was V23's nursing judgment. V23 also stated V23 administered antiˆnausea medication, but no documentation of antiˆnausea medication administration was found in the electronic medical record at the time of review; V23 confirmed the lack of documentation and stated V23 was unsure of the time the medication was given. R1's EHR contains a late entry nursing progress note on [DATE] at 3:10 PM by V23 LPN which stated: V23 checked in on resident to assess pain and nausea. Resident noted sleeping in the bed on her left side. Respirations even and unlabored. Call light in reach. On [DATE] at 9:35 AM, V37 Director of Nursing (DON) stated V23 LPN should have documented the change in R1's condition and notified the physician promptly after V60 CNA reported that R1 appeared more lethargic, pale, and weak. On [DATE] at 8:38AM, V2 Regional Nurse Consultant confirmed the nurses should have assessed, followed up and documented R1's condition. R1's EHR contains a progress note completed by V62 NP dated [DATE] at 10:12 AM documenting that (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance guidelines for this policy documents that circumstances requiring notification include: 1. Accidents a. Resulting in injury. b. Potential to require physician intervention. 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. The facility's Oxygen Administration Policy dated [DATE] documents that oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. Definitions: Oxygen therapy is the administration of oxygen at concentrations greater than that in ambient air (2.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia. Hypoxia means decreased perfusion of oxygen to the tissues. Policy Explanation and Compliance Guidelines: Oxygen is administered under orders of a physician, except in the case of an emergency. In such case oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 2. Personnel authorized to initiate oxygen therapy include physicians, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and respiratory therapists. 3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. 12. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen.

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	145031	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab & Nursing of Normal	510 Broadway Normal, IL 61761

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to employ a full-time certified dietary manager. This failure has the potential to affect all 83 residents.Findings Include:On 03/23/26 at 10:15am, V17 Dietary [NAME] stated there was not a Certified Dietary Manager (CDM) when asked if there was a CDM.On 03/23/26 at 2:00pm, V43 Corporate Dietary Manager stated the facility employed a CDM V44 who works part time.On 03/24/2026 at 09:15am, V43 Corporate Dietary Manager stated the facility does not have a full time Certified Dietary Manager at this time. V43 stated V44 works every Tuesday, Thursday and Friday.On 03/24/2026 at 09:20am, R15 Resident Council President, stated the facility only has a part-time CDM and V44 is usually unavailable.On 03/24/2026 at 09:25am, Employee Roster review documents V44 CDM as a part-time employee. On 03/24/2026 at 2:27pm, V44 CDM was unavailable for interview due to not being in the facility at this time. V44 did not answer the telephone at the time call was placed.The facility's midnight census dated 3/22/2026 documents that there are 83 residents that reside in the facility. R15's Care plan dated 06/24/2023 documents an admission date of 06/20/2023, care plan documents diagnosis of Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Localized Swelling, Mass and Lump, Essential (Primary) Hypertension, Post-Traumatic Stress Disorder, Gastro-Esophageal Reflux Disease With Esophagitis, Atherosclerotic Heart Disease Of Native Coronary Artery with Angina Pectoris, Myocardial Infarction, Diseases Of The Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism, and Generalized Epilepsy and Epileptic Syndromes. R15's Minimum Data Set, dated [DATE] documents R15 is cognitively intact.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow the menu as printed/posted. This failure has the potential to affect all 83 residents. Findings Include:On 03/23/2026 at 12:10pm, the posted lunch menu in the dining room documents Ravioli bake, Cauliflower, Bread Stick, Apple Orchard Bar and a beverage. On 03/23/2026 at 12:15pm, lunch observation was conducted in the main dining room. Residents received a main course of ravioli bake, Vegetable of the day was to be cauliflower which some residents received, some residents received mixed vegetables due to kitchen running out of cauliflower, no dessert was served on the tray at time of distribution.On 03/23/2026 at 12:20pm, conversations with random residents stated they would have preferred to have the cauliflower over the mixed vegetables and that the kitchen frequently runs out of various foods.The grievance log documents on 03/2/26 a resident and their power of attorney had concerns with missing food items.The grievance log documents on 01/07/26 resident council concern of facility running out of food.The grievance log documents on 01/15/26 a resident filed concern that the kitchen staff stated they run out of food items.Resident council minutes dated 1/7/26 documents the kitchen does not have enough food and runs out of things.On 03/23/2026 at 1:05pm, R11 stated most of the time the kitchen sends different food than what is on the menu.On 03/23/2026 at 1:56pm, R10 stated the menu and what food is served often do not match.On 03/23/2026 menu documents lunch meal as ravioli bake, cauliflower, bread stick, Apple orchard bar and a beverage.On 03/23/2026 at 10:15am, V17 cook stated today's menu is cheese ravioli, cauliflower, bread stick and ice cream. V17 stated there is no apple orchard bar.On 03/25/2026 at 11:25am, V43 Corporate Dietary Manager confirmed on 03/23/25 the lunch meal cauliflower was substituted after running out due to not having enough supply and the apple orchard bar was not prepared and served by staff. On 3/23/26 at 1:37pm, V16 Dishwasher stated that sometime in February that all the residents received for breakfast was a donut and fruit, but V16 is not sure why. V16 stated they ran out of Cauliflower today because they only had one (1) bag, and they offered mixed vegetables as an alternative. V16 stated the kitchen runs out of food and is unable to follow the menu frequently. R11's Care Plan documents an admission date of 07/31/2025, care plan documents diagnosis of Anemia, Essential (Primary) Hypertension, Personal History of Other Venous Thrombosis and Embolism, Benign Prostatic Hyperplasia Without Lower Urinary Tract Symptoms, Gout, Localized Edema, Insomnia, Chronic Diastolic (Congestive) Heart Failure, Hyperlipidemia, Morbid (Severe) Obesity Due to Excess Calories, Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, and Peripheral Vascular Disease. R11's Minimum Data Set, dated [DATE] documents R11 is cognitively intact.R10's Care plan documents an admission date of 03/05/2026, care plan documents diagnosis of Hyperlipidemia, Essential (Primary) Hypertension, Lichen Simplex Chronicus, Abnormal Levels of Other Serum Enzymes, Other Malaise, Lymphedema, Age-Related Physical Debility, Non-Pressure Chronic Ulcer of Right Calf with Unspecified Severity, Non-Pressure Chronic Ulcer of Left Calf, Cellulitis of Left Lower Limb, and Metabolic Encephalopathy. R10's Minimum Data Set, dated [DATE] documents R10 is mildly cognitively impaired.The facility's midnight census dated 3/22/2026 documents that there are 83 residents that reside in the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review the facility failed to hold and serve food at 135* Fahrenheit degrees or above. This failure has the potential to affect all 83 residents.Findings Include:On 03/23/2026 at 12:15pm, three (3) random lunch trays being plated at the serving window for resident consumption had a temperature of the ravioli bake taken at 108 degrees Fahrenheit.On 03/23/2026 at 12:15pm, lunch observation was conducted in the main dining room included the temperatures of random meal trays. One meal tray contained the main course of baked ravioli at a temperature of 95.3 degrees Fahrenheit. Another meal tray containing two (2) hamburger patties on buns, the hamburger meat recorded temperature 79.5 degrees Fahrenheit and the last tray temperature in the dining room contained cauliflower as the vegetable temperature of 86 degrees Fahrenheit.On 03/23/2026 at 12:15pm, V18 Certified Nurse's Assistant confirmed the temperatures of the food trays as the temperatures were being taken on the food trays being served in the dining room to residents.On 3/23/26 at 1:37pm, V16 Dishwasher stated that the food is not usually cold but today it might have been because just before serving the steam table broke down.On 3/25/26 at 11:25am, V43 Corporate Dietary Manager confirmed the steam table was broken on 3/23/26. V43 stated while observing meals the staff would open the doors of the hot cart, remove a food tray and take it to the resident leaving the doors of the hot cart open which allows the food to cool. Food temperature policy dated 11/10/21 documents the policy is to ensure food safety the hot food is cooked to a minimum safe temperature and is held at no lower than 135 degrees Fahrenheit. Page two of the same policy documents hot food holding temperatures are taken and recorded for food on the steam table. Hot food is held on the steam table at 135 degrees Fahrenheit or higher.The grievance log review documents on 3/4/26 that meat needs to be cooked more precisely, on 2/4/26 that meal was unappetizing, the potatoes were cold and undercooked, and the food is coming out cold to rooms and the dining room.Resident Council minutes dated 2/4/26 document the meat is overcooked, and the food is cold.The facility's midnight census dated 3/22/2026 documents that there are 83 residents that reside in the facility.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to serve the dinner meal during the posted time of 5:30pm to 6:30pm. This failure has the potential to affect all 83 residents.Findings Include:R11's Care Plan documents an admission date of 07/31/2025, care plan documents diagnosis of Anemia, Essential (Primary) Hypertension, Personal History of Other Venous Thrombosis and Embolism, Benign Prostatic Hyperplasia Without Lower Urinary Tract Symptoms, Gout, Localized Edema, Insomnia, Chronic Diastolic (Congestive) Heart Failure, Hyperlipidemia, Morbid (Severe) Obesity Due to Excess Calories, Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, and Peripheral Vascular Disease. R11's Minimum Data Set, dated [DATE] documents R11 is cognitively intact. On 03/23/2026 at 1:05pm, R11 stated on an unknown date in February that the dinner meal did not arrive until 8:30pm. V29 (R11's) family, at bedside confirmed R11 spoke to V29 in late February about not being served dinner till 8:30pm.On 03/24/2026 at 09:06am, V48 Registered Nurse stated and confirmed there was an unknown date in late February that the dinner meal was not served until after 8:00pm.On 03/24/2026 at 09:08am, V47 Registered Nurse stated on an unknown date in February the dinner meal was served very late due to the kitchen staff calling in.On 03/24/2026 at 09:14am, V37 Director of Nursing confirmed on an unknown date in February the dinner meal was served very late due to the kitchen staff calling in. V37 stated some of the certified nurses' aides went into the kitchen to help prepare the dinner meal.On 03/24/2026 at 11:30am, V43 Corporate Dietary Manager confirmed on 02/25/26 that the evening meal was served late due to kitchen staff shortage due to staff calling in. The grievance log review documents on 02/25/26 the dinner meal was served late.Resident Council minutes dated 1/7/26 at 10:07am documents meals are served late. The facility's midnight census dated 3/22/2026 documents that there are 83 residents that reside in the facility.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review, the facility failed to ensure staff maintained professional standards of conduct, including accurate, truthful, and timely documentation in the medical record for four (R4, R7, R15, and R20) of four residents reviewed for falsification of records/reports for a total sample of 23 residents.Findings Include:Review of the Point of Care (POC) Audit Report printed on 3/27/2026 documents R4, R7, R15 and R20 were included on the list of residents that have missing documentation for Activities of Daily Living (ADL): Bathing on the POC Audit Report for the period of 1/5/2026 through 3/26/2026.On 3/31/2026 at 10:48 AM, V5 Certified Nurse Assistant (CNA) stated V5 was given a four-page list of residents V5 needs to complete retroactive documentation on. V5 stated V5 was not comfortable going back to document from the past days because V5 does not remember what all happened. V5 stated V5 had to make up information which V5 was not comfortable with. V5 stated V5 was told V5 would be taken off of the schedule, and V5's job will be on the line if V5 does not complete the documentation.On 03/31/2026 at 1:15 PM, V7 CNA stated V7 received a four-page list of residents identifying tasks V7 allegedly failed to document on. V7 stated V7 was instructed to complete documentation retroactively for the period of January 7, 2026, through March 2026. V7 stated V69, Certified Nursing Supervisor, informed V7 that failure to complete the missing charting for the listed residents would result in removal from the work schedule, termination of employment, and potential revocation of V7's CNA license. V7 stated V69 indicated these directives originated from Corporate. On 03/31/2026 at 1:26 PM, V69 Certified Nursing Supervisor stated V3 provided V69 with a list of residents and instructed V69 to distribute the list to CNAs. V69 reported V69 was directed that staff members would be removed from the schedule if the required documentation was not completed. V69 further stated V69 was acting as a middleman in communicating these instructions and reiterated CNAs who failed to complete their charting would be removed from the schedule.On 3/30/2026 at 1:26 PM, V15 CNA stated V15 received a list of residents V15 needs to go back and document the care V15 provided from March 7, 2026, to current date.On 3/30/2026 at 1:33 PM, V8 CNA stated V8 received a list of residents V8 needed to go back, and document care provided all the way back from January 2026. V8 stated V8 was told V8 will be taken off the schedule if V8 does not complete the documentation. V8 stated V8 documented N/A on most documentation because V8 did not have any clue on who V8 was charting on and did not want to lie on the documentation because V8 does not remember what care V8 provided on those days. V8 stated some of the required tasks were showers and meals and other tasks mostly on day shifts. V8 stated when V8 goes back to document, there were other tasks required to complete other than showers.On 3/30/2026 at 1:42 PM, V3 Regional Nurse Consultant stated V3 ran a report of missing documentation and asked V69 Certified Nursing Supervisor to have nursing staff complete the documentation so there were no holes in the report. V3 stated V3 does not know how far back V3 ran the report for. V3 stated V3's expectation was whoever was assigned that day must go back and complete the documentation.Review of the facility policy for documentation in Medical Record with revised date 02/02/2026 documents each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through compete, accurate, and timely documentation. Policy explanation and compliance guidelines documents:Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.Documentation shall be timely and in chronological order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to perform timely testing of residents with respiratory infection symptoms during a known Respiratory Syncytial Virus (RSV) outbreak for two of five residents (R3, R19) reviewed for infection control in the sample of 23 residents.Findings Include:On 3/25/26 at 9:07 am, V38 Assistant Director of Nursing (DON)/Infection Preventionist (IP) stated the facility had been in an RSV (Respiratory Syncytial Virus) outbreak which affected eleven residents. V38 DON/IP also stated that there was a delay in testing some residents because of agency staff using the wrong materials, which V38 caught after returning to work after the weekend.The ongoing Infection Control Log documents the first confirmed case of RSV on 2/20/26.On 3/25/26 at 9:40 am, V2 [NAME] President of Clinical Services stated that the facility policy and Department of Public Health guidance is to test for COVID-19 infection first when a resident presents with respiratory illness, even during the RSV outbreak. V2 then stated that the delay in testing for RSV was because the facility was having trouble getting swabs to test for RSV.1.On 3/24/26 at 9:12 am, R3 was sitting up in a wheelchair in R3's room. R3 appears clean and well groomed. R3 stated R3 hasn't had much of a voice for a week or so since being sick. R3's Laboratory Tests dated 2/24/26 documents R3 was tested for RSV, which was negative.R3's Progress Notes document the following:2/27/26 - R3 tested negative for RSV but is still having congestion.3/2/26 - R3's oxygen saturation is 89%, started on two (2) liters of oxygen and physician notified due to not receiving a response from the physician over the weekend.R3's submitted laboratory test dated 3/2/26 for RSV documents The specimen collected is not acceptable for the test ordered. Please submit a nasopharyngeal swab in a red cap viral transport medium.R3's next Laboratory Test dated 3/3/26 documents R3 tested positive for RSV.2. On 3/24/26 at 9:25 am, R19 was resting in bed and appeared clean and well groomed. There was an EBP (Enhanced Barrier Precaution) sign on R19's room door.R19's Progress Notes dated 2/27/26 documents R19 spiked a fever of 102.1 last night. Denies shortness of breath. Physician notified and awaiting response. R19 was tested for COVID-19 at this time and was negative.R19's Progress Notes dated 3/1/26 documents R19 has wheezing in bilateral upper lobes. Physician notified and chest x-ray ordered. Was tested for COIV-19 again, which was negative. R19 then swabbed for RSV, COVID and Influenza.R19's Laboratory Test documents, the RSV, COVID and Influenza specimen were collected on 3/2/26 with results of a positive RSV test reported to the facility on 3/3/26.The facility's Infection Prevention and Control Program Policy dated 2/10/26 documents the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The designated Infection Preventionist is responsible for the oversight of the program and monitors staff and resident exposures, surveillance and epidemiological investigations of exposures to infectious disease.