STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145183	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Danville	620 Warrington Avenue Danville, IL 61832

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to provide care in a manner and environment that promotes resident's independence and dignity while dining for two (R7, R46) of 18 residents reviewed for residents' rights in a sample size of 51. Findings include: R7's care plan, dated 12/7/24, documents R7 has a diagnosis of Multiple Sclerosis and bilateral cataract age related disease. R7 is a social person and enjoys people. R46's care plan, dated 9/17/24, documents R46 is a social person and enjoys people. R46's has a diagnosis of severe protein deficiency malnutrition as well as a diagnosis of dysphagia that requires assistance and supervision with fluid intake and meals. On 03/31/25 at 12:15 pm The noon meal in the main dining was served. R7 and R46 were served plated meals on cafeteria style trays, while other residents seated at the same table were served by removing plates from trays and placing in front of resident along with utensils needed for the meal. R7 was not properly positioned in a low seated wheelchair resulting in R7's shoulders being level with the edge of the dining table. R7 appeared to be struggling to identify where items were placed on her plate as well as removing food off of the plate and tray to eat. At 12:45 pm V11, certified nursing assistant (CNA), stood over R7 to cut food and provide feeding assistance while conversing with V10, CNA, across the dining table. V10, CNA, stood slightly behind R46's right shoulder and leaned over R46 to cut up food and open condiments. On 4/1/25 at 11:49 am, R7 was sitting at the dining room table positioned correctly in the wheelchair. R7's upper chest was level with the edge of the table. R7 struggled to bring utensils over the table to scoop food. No staff assisted R7 during the meal. At 12:00 pm, R46 was sitting in a wheelchair and R46's upper shoulder/neck area was level with the edge of the table. No staff assisted R46 during the meal. At 12:42 pm, both R7 and R46 exited the dining room without eating any of the lunch meal. On 4/2/25 at 2:00 pm, V21, Registered Nurse (RN), stated R7 and R46 should be provided something like an adjustable bedside table in the dining room so they can still have the socialization while maintaining their dignity. V21 further stated that staff standing over residents while feeding is unacceptable. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:38 pm on 4/2/25, V2, Director of Nursing (DON), stated R7 and R46 should be accommodated in the dining room with tables that allow proper alignment enhancing the residents' ability to eat meals independently while maintaining dignity and socialization. V2 further stated staff should not be standing while feeding residents nor should they be standing behind any residents while cutting up food or assisting with feeding. Facility policy titled Dignity with last revision date of 4/23/18 documents the facility shall promote resident independence and dignity while dining by avoiding staff standing over residents while assisting them to eat and refrain from practices demeaning to residents such as ignoring their individual needs and preferences.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review the facility failed to develop an individualized care plan that included interventions for end of life care. This failure has the potential to affect one (R76) of one resident reviewed for Hospice on a sample list of 51. Findings include: The hospice admission evaluation note dated 1/8/25 documents that R76 was admitted to (Hospice Company). On 04/01/25 at 01:14 PM, V2, Director of Nursing (DON) stated that the facility communicates with the Hospice team via a communication book and that R76's care plan should be in the communication book. V2 provided the communication book and there was no communication found on R76. On 04/02/25 at 09:21 AM , V9 Registered Nurse/Care Plan Coordinator stated that R76 is on hospice and should have a care plan with interventions in place. V9 stated V9 is new to this position, V9 started in January 2025 and is trying to catch up. On 04/02/25 at 09:31 AM, V2, stated that R76 should have had a care plan put in place when R76 was admitted to hospice. On 04/02/25 at 1:53 PM, V2 provided R76's hospice plan of care dated 1/10/25. V2 stated that the hospice care plans come from Hospice, and she will get it from R76's case manager.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to review and revise a Care Plan in a timely manner for one (R76) of eighteen residents reviewed for advanced directives on the sample list of 51. 04/01/25 01:21 PM, R76's Care Plan dated 1/9/25 documents that R76 is a full code. On 04/01/25 at 12:48 PM, R76's medical record documents that she signed a code status form on 1/3/25 documenting that R76 doesn't want to be resuscitated. On 4/2/25 at 12:45 PM, V9 Care Plan Coordinator stated that social services usually take care of getting a resident's code status form signed and put into the medical record. V9 stated that she noticed today that R76 was a full code on the care plan. V9 stated the code status should have been updated on the care plan as soon as possible after it was signed. On 4/2/25 at 12:50 PM, V28 Social Services stated that she should have entered R76's code status in the medical record.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the licensed staff maintains a current state license. This failure has a potential to affect all 79 residents in the facility. Findings include: On [DATE], V42's employee file was requested and reviewed. V42's file contained the nursing license verification of LPN (Licensed Practical Nurse) license was conducted through the Illinois Department of Federal Professional Regulations site on [DATE]. The license verification showed V42's LPN license will expire on [DATE]. A copy of V42's nursing license was in the employee file with an expiration date of [DATE]. On [DATE] at 2:55 PM, V41 Human Resources stated that the professional licenses are kept in the employee file and in a binder. V41 checked the license binder and was unable to locate the new nursing license for V42. V42's employee file contained the nursing license that expired on [DATE]. On [DATE], V42's timecard and the facility daily staffing logs shows that V42 worked in the facility on [DATE], [DATE], and [DATE]. On [DATE] at 9:02 AM, V41 stated V41 is responsible for ensuring that the nursing licenses are current and copies of current licenses are placed in the employee record and the license binder. When asked about the schedule and nursing assignments, V41 stated that V41 attempts to keep the nurses on the same hall, however, at times the nurses do have to float to a different hall to cover call offs. The facility's LPN job description dated [DATE] states one of the qualifications of employment is Licensed Practical Nurse with current unencumbered state licensure. Long-Term Care Facility Application for Medicare and Medicaid dated [DATE] shows 79 residents residing in the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to provide oral care for one (R55) of 24 residents reviewed for ADL (Activities of Daily Living) care in a sample list of 51. Findings Include: The facility's policy Oral Hygiene updated 1/1/14 states: Oral care is an essential part of morning and evening care. Note: Some residents may require oral hygiene after each meal due to inability to rinse out food debris. R55's current diagnosis list includes the following diagnoses: Dysphagia following Cerebral Vascular Accident, Seizures, Anxiety, and Dementia with Behaviors. On 1/31/25 at 10:00AM R55 was lying in bed sleeping. R55 was breathing through R55's mouth with her mouth open. A large amount of crusty gray secretions were noted on R55's lips and oral cavity. On 4/2/25 at 10:00AM V8, ADON (Assistant Director of Nursing) verified it is the facility's expectation all residents who require assistance with oral care should receive it as needed. V8 also verified this is particularly important in residents with Dysphagia (difficulty swallowing).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to document assessments and obtain treatment orders for newly identified pressure ulcers, develop a care plan for pressure ulcers, develop and implement pressure relieving interventions, and timely implement treatment orders for one of four residents (R38) reviewed for pressure ulcers in the sample list of 51. Findings include: The facility's Pressure Injury and Skin Condition assessment dated [DATE] documents the following: A Braden pressure ulcer risk assessment will be completed on admission, quarterly and as needed, and nurses will complete weekly skin assessments for identified residents. Document an initial wound assessment in the resident's medical record when pressure ulcers are identified. The physician will be notified at the earliest sign of a pressure ulcer. The care plan will be updated to include skin integrity, goals, and interventions. Physician ordered treatments will be documented on the Treatment Administration Record and other nursing measures will be documented on the weekly wound assessment or nursing notes. On 3/31/25 at 12:16 PM R38 was sitting in a stationary chair in R38's room. There was no therapeutic cushion in R38's chair. R38 stated R38 has a wound on R38's bottom and one on her heel. R38 was unsure how long the wounds have been there. R38 stated staff have to assist R38 with walking/transfers and incontinence cares/toileting. On 3/31/25 at 4:18 PM and on 4/1/25 at 10:03 AM, 12:47 PM, 1:11 PM, and 3:25 PM R38 was sitting in the stationary chair in her room with no therapeutic cushion. On 4/01/25 at 3:38 PM V8 Assistant Director of Nursing transferred R38 from the chair to the bed and administered R38's pressure ulcer treatments. R38 had a small scabbed wound on the right heel and a superficial stage two pressure ulcer of the sacrum. R38's skin to left heel was intact and V8 applied a protective dressing. V8 offered for R38 to stay in bed but R38 declined. V8 assisted R38 into the stationary chair that did not contain a pressure relieving cushion. V8 stated a wedge cushion has not been used for R38, staff should be using a pillow to reposition R38 onto her side when she's in bed, repositioning/turning R38 every two hours, and this should be documented as part of the Certified Nursing Assistant (CNA) charting tasks. V8 stated an air mattress is implemented for stage three or four pressure ulcers or after trialing a wedge cushion in bed for stage one and two pressure ulcers. V8 stated typically a pressure relieving cushion is implemented, but one was not used for R38 since R38 does not like to sit in the wheelchair. V8 stated weekly skin assessments should be documented on shower days on the shower sheets. V8 stated V8 is notified of new skin issues, an assessment is completed, the physician should be notified to obtain treatment orders and determine if a referral to V50 Wound Physician is needed. V8 stated V9 Care Plan Coordinator is responsible for updating wounds on the care plan and prior to that the former wound nurse was responsible. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's admission Minimum Data Set (MDS) dated [DATE] documents R38 as dependent on staff for toileting, substantial/maximal staff assistance for bathing, and partial/moderate staff assistance for turning in bed, transfers, and walking. R38's MDS dated [DATE] documents R38 is cognitively impaired, R38 had a significant weight loss within one or six months, requires substantial/maximal staff assistance with toileting, bathing, and turning in bed; and partial/moderate staff assistance for transfers and walking. This MDS documents R38 has one stage one pressure ulcer and two facility acquired pressure ulcers. R38 does not use a pressure relieving device in chair, has not had nutritional interventions for skin, and is not on a turning and repositioning program. R38's Braden Assessments dated 12/26/24, 1/27/25, and 2/25/25 document R38 is at risk for developing pressure ulcers. R38's care plan dated 11/26/24 documents R38 has a potential for impaired skin integrity with two interventions - assess and record changes in skin status and report changes to the physician. This care plan does not include pressure relieving interventions or R38's pressure ulcers. R38's Physician Order dated 11/26/24 documents may use use wheelchair pressure relieving cushion pressure relief and/or wound prevention. There is no documentation that this was implemented. R38's Nursing Note dated 1/20/25 at 1:01 PM documents R38's family and Nurse Practitioner were notified of R38's stage two pressure ulcer. There are no documented assessments of this wound until 1/22/25. R38's Nursing Notes dated 1/26/25 at 10:44 AM documents R38 had two small open areas to the left and right buttocks and pressure injuries to both heels. Bordered foam dressings were applied to both heels. There is no documentation that the physician was notified of these wounds or that any pressure relieving interventions and treatments were implemented at that time. R38's Skin Condition Report dated 2/20/25 documents R38 had a very small opening starting to R38's right heel and redness to the left heel with preventative measures put in place. This assessment doesn't document what preventative measures were implemented. R38's Physician Order dated 2/26/25 documents to apply heel boots in bed. R38's Wound Management Summary dated 1/22/25, recorded by V50, documents R38's stage one sacral pressure ulcer measured 6.5 centimeters (cm) by 5 cm and zinc cream twice daily as the treatment. R38's Wound Management Summary dated 1/28/25, recorded by V50, documents R38's stage one sacral pressure ulcer measured 6 cm x 5 cm and the treatment was zinc cream twice daily. R38's January Treatment Administration Record documents calcium alginate treatment was implemented on 1/20/25 and zinc cream was implemented on 1/30/25 for R38's sacral pressure ulcer. R38's Wound Management Summary dated 2/5/25 documents R38's sacral pressure ulcer deteriorated to stage two and measured 4.5 x 3 x 0.01 cm. R38's Wound Management and Summary dated 2/25/25 documents R38's stage two pressure ulcer measured 0.5 x 0.6 x 0.01 cm and R38's left heel stage two pressure ulcer measured 2.2 x 3 x 0.01 cm. R38's Wound Management and Summary dated 3/26/25 document R38's stage two sacral pressure ulcer measured 2.8 cm x 2 cm x 0.01 cm. R38's right heel stage two pressure ulcer measured 1 cm 1.5 cm x 0.01 cm. R38's left heel stage two pressure ulcer measured 1 cm x 0.8 cm 0.01 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/01/25 at 1:11 PM V48 CNA stated pressure relieving interventions are listed in the resident's Kardex (information pulled from the care plan). V48 stated R38 is suppose to be repositioned every two hours and uses pressure relieving boots when in bed. On 4/01/25 at 1:24 PM V49 CNA stated R38 lays down during the day after meals and sits on a pillow in R38's chair when R38 asks for it. V49 stated R38 does not use a pressure relieving cushion in the chair. On 4/1/25 at 4:00 PM V8 confirmed R38 has an order that a pressure relieving cushion may be used and that this order was not implemented. V8 confirmed the zinc cream was not implemented until 1/30/25. V8 stated V50 rounds on Tuesdays and submits V50's progress notes on Wednesdays for V8 to implement and V8 does not round with V50. V8 stated the calcium alginate coccyx wound treatment was implemented per standing orders on 1/20/25 and there are no documented assessments of this wound that day. V8 confirmed this treatment order should have changed to zinc cream per V50's notes dated 1/22/25 and 1/28/25. V8 confirmed there are no initial assessments of R38's heel wounds first noted on 1/26/25 and no treatment or preventative orders for these wounds until 2/23/25. V8 stated a bordered foam dressing and boots should have been implemented as preventative measures on 1/26/25. V8 stated R38 had COVID-19, R38 had lost weight and was in bed more which were contributing factors in development of pressure ulcers. On 4/02/25 at 9:26 AM V8 confirmed R38's care plan had not been updated with pressure relieving interventions or R38's pressure ulcers. V8 stated V8 was unable to locate documentation of pressure relieving interventions that were implemented, besides the pressure relieving boots initiated in February. V8 stated there were no documented shower sheets for R38 for January and February.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement nutritional interventions, timely implement dietitian recommendations, care plan for weight loss, and timely notify the dietitian, physician, and resident representative of significant weight loss for three of four (R38, R72, R36) residents reviewed for nutrition in the sample list of 51. These failures resulted in ongoing and significant weight loss for R38 and R36. Findings include: The facility's undated Weight Assessment and Intervention policy documents the following: Weights will be monitored at least monthly and as recommended by the interdisciplinary team (IDT). Residents on fluid management programs will be weighed frequently to monitor changes in fluid status and if weight loss is desirable or related to fluid loss, this will be documented. Weights are documented in the resident's medical record. Weight changes of 5% or more will have a re-weigh to verify accuracy. Once the weight change is verified, nursing staff will notify the physician, Registered Dietitian (RD), Dining Services Manager, or other members of the IDT and this notification must be confirmed in writing. The weight log will be reviewed monthly by the RD to evaluate negative trends and determine significant changes and will discuss interventions with the resident's representative. A one month loss of 5% is significant and greater than 5% is severe. A three month loss of 7.5% is significant and greater than 7.5%. A six month loss of 10% is significant and greater than 10% is severe. The physician with the IDT will identify conditions or medications that may be contributing to weight loss. Undesirable weight loss will be care planned to include the problem, goals, and interventions. Interventions will be based on resident choice, nutritional needs, contributing factors, medication effects, use of supplements, and end of life decisions. 1.) On 3/31/25 at 12:16 PM R38 stated R38 is unaware if R38 has lost any weight or if anything has been done to address R38's weight loss. On 3/31/25 at 1:31 PM R38 had finished eating lunch in R38's room. R38 ate half of the chicken patty, all of the baked potato, no broccoli, 75% of fruit, and drank all of the nutritional shake. On 4/01/25 at 12:47 PM R38 was finished eating lunch in R38's room. R38 ate almost all of the meatballs, and a few bites of vegetable blend, mashed potatoes, and pineapple. R38 drank all of the nutritional shake. R38 stated R38 did not want to eat anymore of the meal. R38's Minimum Data Set (MDS) dated [DATE] documents R38 has moderate cognitive impairment, had a significant weight loss within the last month or last six months, is not on a prescribed weight loss regimen, and has one stage one and two facility acquired stage two pressure ulcers. R38's active care plan does not address R38's significant weight loss. R38's ongoing weight log documents: admission weight 104 pounds (lbs) on 11/26/24 104 lbs on 11/28/24 92 lbs on 12/11/24 (11.54% loss in less than one month) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	96.4 lbs on 12/30/24 90.4 lbs on 1/27/25 (6.22% loss in one month) 92 lbs on 3/2/25 93 lbs on 4/1/25 R38's Nursing Note dated 12/24/24 documents R38 tested positive for COVID-19 and was placed on isolation. R38's meal intake report dated 12/1/24-2/28/25 document R38 ate 50% or less for 44 meals in December, 69 meals in January, and 57 meals in February. R38's meal intake report dated 3/6/25-4/4/25 document R38 ate 50% of less for 73 meals. There is no documentation in R38's medical record that R38's significant weight loss noted on 12/11/24 was reported to V43 RD or evaluated by V43 until 12/23/24. R38's Request for Diet Change dated 12/23/24 documents V43 RD recommended adding nutritional shake three times daily. This form was not signed by the physician until 12/30/24 and there is no documentation that this was implemented until 1/6/25. There is no documentation in R38's medical record that a physician was notified of R38's weight loss other than this diet change request. R38's January 2025 Medication Administration Record (MAR) documents nutritional shakes three times daily was implemented on 1/6/25. R38's Nutrition/RD Note dated 1/20/2025 documents R38 is receiving treatment for a stage two pressure ulcer. R38's Nutrition/RD Note dated 2/25/25, recorded by V43, documents R38's weight is down 6.5% in one month and 13.4% in three months, R38 has stage two pressure ulcers to left buttock and sacrum, and R38's meal intakes are poor to fair. V43 recommended adding nutritional supplement 90 milliliters (ml) three times daily for extra calories and protein. R38's March MAR documents nutritional supplement 90 milliliters three times daily was implemented on 3/4/25. There is no documentation in R38's medical record that V44, R38's Family, was notified of R38's significant weight loss prior to 2/25/25. R38's Care Conference dated 2/25/25 documents V44 was notified of R38's weight loss and weight loss was expected due to age and appetite level. R38 was refusing to eat and upset with family due to nursing home admission. R38 was noted to eat desserts prior to meal so may try incorporating yogurt and applesauce. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/2/25 at 1:32 PM V43 RD stated V43 is at the facility one day per month and also works remotely. V43 stated V43 has to do a lot of research herself because the facility does not have a great system for referring residents to V43. V43 stated V43 has to run a report during her visit to determine new admissions and a weight report from the beginning of the month to the beginning of the next month to determine significant weight loss. V43 stated it would be great if the facility would notify V43 at the time the significant weight loss occurs since V32 goes by the weights recorded at the beginning of each month. V43 stated V43 does not have time to run a weight report each week and relies on the facility to do that. V43 stated V43's biggest concern is if the resident is eating less than 50% of each meal. V43 stated V43's recommendations should be implemented within a week and V43 provides recommendations to the facility within 24 hours of V43's visit. V43 stated there may be a delay due to the facility having to wait for the physician or nurse practitioner to approve V43's recommendations. V43 stated V43 first evaluated R38 on 12/23/24, R38's advanced age and COVID-19 could have contributed to R38's weight loss, as well as R38's decreased appetite. V43 confirmed the facility should also report significant weight loss to the physician for review. V43 stated R38's additional weight loss could have possibly been prevented if the facility had reported R38's weight loss in December prior to V43's visit. V43 stated the facility should be monitoring weights closely to catch weight loss sooner. On 4/2/25 at 2:14 PM V2 Director of Nursing (DON) stated V3 Dietary Manager (DM) is responsible for notifying V43 of weight loss and V43's recommendations are given to nursing to follow up to obtain physician approval. V2 stated we have a new medical director , V30, that started in January who is here two or three times, and initially V30 did not want to sign off on V43's recommendations until V30 got to know the residents. V2 stated there have also been changes in the facility's nurse practitioners and the facility used to have nurse practitioners that were in the facility daily. V8 Assistant DON stated nursing staff are responsible for reporting weight loss to V3 who notifies V43. Both V2 and V8 stated physician notification would be in a nursing note or physician progress note. Neither V2 or V8 were aware of who has been notifying resident representatives of significant weight loss. V8 stated that is something nursing should probably be doing and this should be documented in a nursing note. V8 confirmed care plans should address weight loss and was unsure if V3 or V9 Care Plan Coordinator was responsible for updating this on the care plan. V2 stated weight loss is reviewed as part of the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings. V2 stated nutritional supplements are recorded on the MAR and physician orders. On 4/3/25 at 11:14 AM V2 stated R38 was initially upset with R38's family for admitting to the facility, R38 was on strike, and refusing to eat. R38's family started coming during meal times and we discovered R38 likes sweets. V2 stated R38's family was notified of R38's weight loss during the care plan meeting on 2/25/25. V2 confirmed R38's diet change request was signed by the physician on 12/30/24 and confirmed there was no other documented notification to R38's family or physician. V2 stated V2 thought R38's weight loss was related to diuretic use. V2 and V34 Regional Nurse Consultant confirmed R38 had no increased or additional doses of diuretics given. V34 confirmed R38's care plan was not updated to address R38's weight loss prior to 4/1/25. V34 stated V3 DM needs to be updating the nutrition/weight loss on the care plan and will need additional training on this. V2 stated the former DON left in November 2024, V2 started as DON on 12/6/24 and is new to this role, and V9 Care Plan Coordinator was trying to catch up on V43's recommendations. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/2/25 at 2:35 PM V3 DM stated V3 is responsible for reporting significant weight loss to V43 RD via electronic mail or phone calls. V3 also runs a weight report weekly that is forwarded to V43 each week but V3 does not document this notification in the resident medical record. V3 stated V43 sends recommendations to V3 and nursing is responsible for implementation. V3 stated weight loss is reviewed during the monthly QAPI meetings and not during the daily IDT meetings. V3 stated V3 only updates the care plans with new supplements/interventions and V9 is responsible for updating the care plan with weight loss. On 4/3/25 at 1:35 PM V3 stated V3 had no electronic mail communication with V43 reporting R36's, R38's or R72's significant weight loss. On 4/2/25 at 3:30 PM V1 Administrator stated significant weight changes is reviewed as part of the morning IDT meetings, but no weight reports are reviewed at that time. V1 stated that is something we are going to start doing and implementing weekly weight meetings. 2.) On 3/31/25 at 10:01 AM R36 stated R36 has lost about 50 lbs since admitting to the facility and was unsure why. On 3/31/25 at 12:39 PM R36 was served lunch in R36's room which consisted of baked potato, broccoli, hamburger, bread with butter, and fruit parfait. R36's meal tray did not include a nutritional shake. R36's meal ticket does not include a nutritional shake as part of the noon meal, but lists instructions that nutritional shakes are not part of R36's fluid restriction. On 3/31/25 at 1:14 PM V31 Certified Nursing Assistant (CNA) stated R36 ate half of the hamburger, all of the dessert, and only bites of the other food. V31 stated R36 used to get nutritional shakes with meals when R36 resided on another hallway, but V31 did not think R36 gets the shakes anymore due to being on a fluid restriction. V46 CNA looked at R36's meal ticket and stated the nutritional shake is not included as part of the fluid restriction. V31 and V46 confirmed the nutritional shakes are served by dietary on the meal trays and R36 did not have a nutritional shake as part of his meal. On 4/01/25 at 12:55 PM R36 was lying in bed and finished eating lunch. R36 ate one meatball, all of his mashed potatoes, half of his pineapple, half of a slice of bread with butter and a few bites of vegetable blend. R36's meal did not include a nutritional shake and the nutritional shake was not listed on R36's meal ticket, only the instructions that the shake is not part of his fluid restriction. R36 stated R36 just doesn't have much of an appetite and R36 is depressed. R36 stated R36 had not told staff that he was feeling more depressed. At 1:15 PM R36's concerns of depression was reported to V45 Registered Nurse (RN) and V45 stated she would follow up on this. R36's MDS dated [DATE] documents R36 has moderate cognitive impairment and had a significant weight loss within one or six months without a prescribed weight loss regimen. R36's active care plan does not address R36's weight loss. R36's active Care Plan does not address R36's weight loss. R36's active physician's orders includes orders for a daily 1600 ml fluid restriction related to Congestive Heart Failure (CHF) as of 11/23/24, nutritional shake daily since 11/24/24, and nutritional supplement 90 ml three times daily as of 4/2/25. R36's March MAR documents nutritional shake daily at noon since 11/24/24 and nutritional supplement 60 ml three times daily since 1/6/25. R36's December 2024-March 2025 MARs do not document any changes in R36's diuretic medications and there is no documentation in R36's medical record that R36 had edema during this time frame. R36's Nursing Note dated 12/20/24 documents R36 tested positive for COVID-19. R36's active weight log includes the following: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	165.8 lbs on 12/2/24 163.7 on 12/7/24 170.3 lbs on 12/9/24 171 lbs on 12/14/24 156.2 lbs on 12/21/24 (5.79% loss since 12/2/24) 153.5 lbs on 1/1/25 (7.42% loss in one month) 153.8 on 1/4/25 149.6 lbs on 2/2/24 146.4 lbs on 2/10/24 147 lbs on 3/3/25 144.6 lbs on 4/2/25 141.1 on 4/3/25 (8.26% loss in three months) R36's meal intake reports dated 12/1/24-2/28/25 document R36 ate 50% or less for 14 meals in December, 11 meals in January, and 23 meals in February. R36's meal intake report dated 3/5/25-4/3/25 documents R36 ate 50% or less for 27 meals. R36's Nutrition/RD Note dated 12/23/2024 at 12:34 PM documents R36's meal intakes vary and a recommendation for nutritional supplement three times daily for extra calories and protein. This recommendation was not implemented until 1/6/25. R36's Nutrition/RD Note dated 2/25/25 at 1:31 PM documents R36's weight down 12.8% in three months, intakes are fair to good for most meals, and R36 receives nutritional shake daily and nutritional supplement 60 ml three times daily. R36's Nutrition/RD Note dated 3/24/25 at 2:05 PM documents R36's weight is down 11% in three months, intakes are fair to good for most meals, and a recommendation to increase the nutritional supplement to 90 ml three times daily. There is no documentation that this was implemented prior to 4/2/25. There is no documentation in R36's medical record that R36's weight loss was reported to R36's physician after 11/20/24 until 3/28/25. As of 4/2/25 there is no documentation in R36's medical record that R36's physician was notified of R36 feeling depressed after this was reported to V45 RN on 4/1/25. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/2/25 at 1:32 PM V43 RD stated R36's appetite is overall fair but varies, and within the last week or so R36's appetite has been poor with meal intakes less than 50%. V43 stated on 3/24/25 V43's assessment noted weight loss and V43 recommended increasing the nutritional supplement to 90 ml three times daily. V43 confirmed R36 has had additional weight loss since then and confirmed that if the nutritional supplement was increased as recommended, it could have helped stabilize R36's weight. V43 stated V43 does not round at the facility until later in the month and the facility should be reporting any weight loss prior to V43's visits. V43 stated no one had reported R36's depressed feelings. V43 would have recommended for R36 to see a therapist or social worker and a pharmacy medication review. On 4/2/25 at 2:35 PM V3 DM stated R36's weight loss is related to CHF, fluid restriction and water weight fluctuation. On 4/3/25 at 11:14 AM V34 Regional Nurse Consultant stated on 2/6/25 R36's Zoloft (antidepressant) was decreased from 100 milligrams daily to 75 milligrams. V34 stated the facility will need to follow up with R36's physician today to report R36's depression symptoms and that the gradual dose reduction failed. On 4/2/25 at 2:14 PM V2 DON confirmed R36's nutritional supplement 60 ml was not started until 1/6/25. On 4/03/25 at 1:35 PM V2 stated V2 found s progress noted dated 11/20/24 that documented physician notification of R36's weight loss. V2 provided this documentation and confirmed this was the only physician notification V2 could locate. 3.) On 3/31/25 at 11:11 AM R72 stated R72 used to weigh around 170 lbs and is now around 150 lbs and was unsure what the facility was doing to address this weight loss. On 3/31/25 at 12:34 PM R72's noon meal was delivered to R72's room and contained a baked potato, chicken patty, broccoli, fruit parfait, and high protein ice cream. At 1:14 PM R72's meal tray was on the hall cart. R72 only ate half of the fruit parfait. R72 did not eat the high protein ice cream. V46 CNA stated R36 does not like sweets so R36 does not eat the ice cream, R36's family brings in food and nutritional supplements. On 4/01/25 at 1:02 PM R72 was in bed with lunch tray at bedside which included vegetable blend, mashed potatoes, and meatballs. R72 ate all of the high protein ice cream and only bites of mashed potatoes and meatballs. R72 stated R72 does not like broccoli and has reported this to staff. R72's meal ticket does not document R72 dislikes broccoli. R72 stated R72 ate a granola bar and drank a nutritional supplement instead of eating yesterday's lunch. R72's active weight log documents the following: 11/14/24 admission weight of 156.2 lbs 165.4 lbs on 12/3/24 172.3 lbs on 12/12/24 157.5 lbs on 1/10/25 (8.59% loss in one month) 154.8 lbs on 1/16/25 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	143.5 lbs on 2/5/25 (16.72% loss since 12/12/24) 148.8 lbs on 3/4/25 149 lbs on 3/12/25 152.6 lbs on 3/21/25 151.2 lbs on 3/26/25 148.8 lbs on 4/2/25 and 4/3/25 R72's Hospital Discharge summary dated [DATE] documents R72 weighed 178.3 lbs. R72's meal intake reports dated 1/1/25-2/28/25 document R72 ate 50% or less for 12 meals in January and 17 meals in February. R72's admission MDS dated [DATE] document R72 admitted with a stage four pressure ulcer. R72's MDS dated [DATE] documents R72 is cognitively intact and has a stage four pressure ulcer. R72's Care Plan dated 11/15/24 documents R72 has a nutritional problem or potential for nutritional problem related to depression and new admission. Interventions include encouraging and monitoring intake of meals and snacks, monitoring and reporting signs of malnutrition including significant weight loss to the physician, and for dietitian evaluation and recommendations. This care plan documents R72 receives a frozen nutritional supplement as of 12/31/24. This care plan has not been updated to include R72's significant weight loss since admission or any new interventions besides the frozen nutritional supplement. There is no documentation in R72's medical record that R72's significant weight loss was reported to R72's physician. R72's Initial Nutritional assessment dated [DATE] documents a recommendation for Prostat 30 ml twice daily to aid with wound healing. This same recommendation is listed in R72's Nutrition/RD Note dated 12/23/24 . R72's December 2024 MAR documents Prostat 30 ml daily was not implemented until 12/31/24. R72's January 2025 MAR documents Prostat was increased to twice daily on 1/6/25. R72's Nutrition/RD Note dated 1/20/2025 documents R72's weight of 172 was higher than usual and current weight of 154.8 lbs is more consistent with R72's prior weights. R72's nutritional interventions include high protein ice cream, nutritional supplement 120 ml, and Prostat 30 ml twice daily. R72's Nutrition/RD Note dated 2/25/2025 documents R72's weight is down 8.9% in one month and 8.1% in three months, and V43 recommended increasing the nutritional supplement to twice daily for extra calories and protein. R72's March 2025 MAR documents nutritional supplement was increased to twice daily on 3/4/25. R72's Nutrition/RD Note dated 3/24/2025 documents R72's weight is down 10% in three months and does not document any new recommendations. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/2/25 at 1:32 PM V43 RD stated R72 admitted with a pressure ulcer and initially had weight gain. V43's initial assessment of R72 was completed on 11/25/24 and V43 recommended Prostat 30 ml twice daily for wound healing. V43 confirmed this was also recommended on 12/23/24 as it had not yet been implemented. V43 questioned the accuracy of R72's weight of 172 and was unsure if R72's weight loss was a true weight loss. V43 stated the facility should have reweigh R72 when R72 returned from the hospital at the end of December 2024. V43 stated R72's weight has since stabilized within a 10 lb fluctuation. V43 stated on 1/20/24 R72 was already on protein ice cream and a daily nutritional supplement. V43 stated V43 was not notified of R72's significant weight loss until V43's visits on 1/20/25 and 2/25/25, and V43 would have given recommendations if V43 was notified sooner. On 4/3/25 at 1:35 PM V2 DON confirmed V2 was unable to locate documentation that R72's significant weight loss was reported to the physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to obtain physician orders for oxygen use and provide hygienic care and storage of nebulizer equipment for two of two residents (R36, R185) reviewed for respiratory care in the sample list of 51. Findings include: 1.) On 3/31/25 at 10:01 AM R36 was in bed wearing oxygen at 3 liters per minute. R36's nebulizer mask and tubing was uncovered in an open drawer of R36's night stand. R36 stated R36 gets daily nebulizer treatments. R36's March 2025 Medication and Treatment Administration Record (MAR/TAR) documents R36 receives Ipratropium-Albuterol nebulizer treatments four times daily and does not include an order and schedule to change nebulizer tubing. On 3/31/25 at 2:10 PM V45 Registered Nurse stated nebulizer tubing and mask should be changed weekly which is done by night shift and documented on the MAR/TAR. At 2:18 PM V45 entered R36's room and verified R36's nebulizer mask was uncovered and on top of R36's night stand. V45 stated night shift is responsible for cleaning the mask nightly and it should be stored in a bag after cleaned and when not in use. V45 stated R36 had refused the morning nebulizer treatment. 2.) On 3/31/25 at 9:41 AM R185 was lying in bed wearing oxygen at 2 liters per minute per nasal cannula. R185 stated R185 has used oxygen since her recent hospital admission. On 4/1/25 at 12:48 PM R185 was lying in bed with oxygen per nasal cannula. There are no active physician orders in R185's medical record for oxygen use as of 4/1/25. R185's nursing notes dated 3/27/25-4/3/25 document R185 admitted to the facility on [DATE] and uses oxygen. On 4/02/25 at 9:26 AM V8 Assistant Director of Nursing stated there should be physician orders for oxygen use and flow rate. On 4/02/25 at 10:22 AM V8 stated R185's hospital discharge orders did not include oxygen orders. V8 stated V8 obtained R185's oxygen orders today. The facility's Nebulizer Medication Administration policy dated 10/9/18 documents to change nebulizer tubing and equipment weekly, rinse and disinfect the nebulizer equipment per manufacturer's instructions or wash pieces with warm, soapy water daily, allow to dry, and store in a plastic bag when dry.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on interview and record review the facility failed to periodically assess psychotropic medication use, identify targeted resident behaviors, attempt nonpharmacological interventions, and avoid duplicate therapy for three residents (R4, R26, R64) of five residents reviewed for unnecessary medications in a sample list of 51. Findings include: The facility's policy Psychotropic Medication revised 2/1/18 states Purpose: To ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per standards of practice, and are prescribed at the lowest therapeutic dose to treat such conditions. The plan to alternatives to psychotropic medication and/or use of psychotropics shall be incorporated into the care plan with suitable goals and approaches. This will be initiated by the resident's needs/problems, goals, and approaches as it relates to the use of psychotropic drugs. 1. R4's current Medication Administration Record (MAR) for April 2025 includes the following psychotropic medications: Olanzapine (antipsychotic) Oral Tablet Give 1.25 mg by mouth at bedtime and Duloxetine Hydrochloride (antidepressant) Oral Capsule Delayed Release Particles (Duloxetine Hydrochloride) Give 30 mg by mouth in the morning. R4's Psychotropic Medication Observation dated 2/24/25 does not include the above medication. No documentation is observed to indicate nonpharmacological interventions were attempted. No documentation is observed to indicate resident specific behaviors were identified and tracked. 2. R26's current Medication Administration Record (MAR) for April 2025 includes the following psychotropic medications: Risperdal (antipsychotic) Oral Tablet (Risperidone) Give 0.25 mg by mouth in the morning and Lexapro (antidepressant) Oral Tablet 10 MG (EscitalopramOxalate) Give 1 tablet by mouth in the morning. No psychotropic medication assessment is documented. No documentation is observed to indicate nonpharmacological interventions were attempted. No documentation is observed to indicate resident specific behaviors were identified and tracked. 3. R64's current Medication Administration Record (MAR) for April 2025 includes the following psychotropic medications: Quetiapine Fumarate (antipsychotic) Oral Tablet 400 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime every Monday through Friday, Quetiapine Fumarate (antipsychotic) Oral Tablet 300 MG(Quetiapine Fumarate) Give 350 mg by mouth at bedtimes every Saturday and Sunday, Melatonin (sleep aid) Oral Tablet 3 MG (Melatonin) Give 2 tablet by mouth at bedtime for insomnia and Risperidone (antipsychotic) Oral Tablet (Risperidone) Give 0.25 mg by mouth two times a day. There is no justification documented for the concurrent use of two antipsychotics for (R64).No psychotropic medication assessment is documented. No documentation is observed to indicate nonpharmacological interventions were attempted. No documentation is observed to indicate resident specific behaviors were identified and tracked. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 2:00PM V2, Director of Nursing verified the above residents should have had documented psychotropic assessments, nonpharmacological interventions, and resident specific behaviors should have been identified and tracked in order to determine resident specific interventions for R4, R26, and R64. V34, Corporate Nurse Consultant was present for this interview and nodded agreement with V2's verification.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to administer medications timely, as ordered, and in accordance with pharmacy instructions resulting in five medication errors out of 25 opportunities, a 20% medication error rate. This failure affects two of five residents (R14, R47) reviewed for medication administration in the sample list of 51. Findings include: 1.) On 4/01/25 at 8:45 AM V13 Registered Nurse (RN) prepared R14's medications. V13 obtained a vial of R14's Cyclosporine 0.05% eye drops and the box contained a label to turn the vial upside down several times prior to use. V13 placed two pumps of topical menthol 5% gel into a medication cup. V13 did not turn the Cyclosporine vial upside down several times prior to administering one drop into R14's eyes. V13 applied the topical menthol gel to R14's knees. R14's April 2025 Medication Administration Record (MAR) documents R14 receives Cyclosporine 0.05 % one drop each eye twice daily and Biofreeze Pain Gel 4% menthol topically to knees four times daily. On 4/01/25 at 9:51 AM V13 verified menthol 5% gel was administered. V13 stated we don't have the 4% menthol gel so the order will need to be changed. V13 confirmed V13 did not turn the Cyclosporine vial upside down several times prior to administration and confirmed this was documented on the pharmacy label. V13 stated V13 did not realize that needed to be done. 2.) On 04/01/25 at 11:53 AM V45 RN administered R47's medications including Coreg 25 milligrams (mg) one tablet and Keppra 750 mg. V45 obtained R47's blood glucose of 116 mg per deciliter and V45 did not administer R47's Novolog insulin. At 12:05 PM V45 stated V13 RN was behind with V13's morning medication pass and V45 was trying to get caught up after taking over the hall for V45. V45 confirmed the Keppra and Coreg were scheduled to be given at 8:00 AM/9:00 AM. V45 stated based on R47's blood glucose, V45 withheld R47's scheduled 10 units of insulin because R47 would bottom out. R47's April 2025 MAR documents to give Keppra 750 mg daily at 9:00 AM and 500 mg daily at 8:00 PM, give Coreg 25 mg daily at 8:00 AM and 8:00 PM, and give Novolog insulin 10 units three times daily before meals. This MAR documents that R47 received the evening doses of Keppra and Coreg as scheduled. There are no physician ordered parameters for withholding R47's scheduled dose of Novolog 10 units. There is no documentation in R47's medical record that R47's physician was notified of the late administration of Coreg and Keppra or that Novolog 10 units was withheld. On 4/02/25 at 12:02 PM V45 confirmed V45 had not notified the physician that R47's morning medications were given late on 4/1/25. V45 stated V45 was not aware that R47 receives additional doses of Keppra and Coreg in the evening. V45 stated V45 sent a note to the nurse practitioner that V45 withheld R47's insulin which V45 should have documented in a progress note. V45 confirmed there are no orders to hold R47's scheduled Novolog insulin. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/02/25 at 11:42 AM V2 Director of Nursing stated the nurse should notify the provider when insulin is withheld without an order and this should be documented in a nursing note. V2 stated there is an hour window before and after the scheduled time to administer medications. V2 confirmed medications given outside of this window with additional scheduled doses during the day need to be reported to the physician, and this should be documented in a nursing note.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to label insulin vials with opened dates, appropriately store medications and destroy discharged resident medications for four of six residents (R187, R186, R47, R82) reviewed for medication storage in the sample list of 51. Findings include: 1.) On 04/01/25 at 1:57 PM the Middle Hall medication room was observed with V47 Licensed Practical Nurse. There was a bottle of R186's Clindamycin 300 milligrams (mg) containing three capsules. There was a bag of three vials of Ceftriaxone 1 gram labeled with R187's name. V47 stated these residents are no longer in the facility and have not been here since V47 started working in the facility a few months ago. V47 stated night shift is suppose to send medications back to the pharmacy. R187's Census documents R187 discharged from the facility on 12/13/24. R186's Census documents R186 discharged from the facility on 12/18/24. On 4/2/25 at 11:42 AM V8 Assistant Director of Nursing (ADON) stated after a resident discharges their medications should be returned to the pharmacy. If the bottles are the resident's from home then those are to be picked up by the resident's family. 2.) On 4/01/25 at 9:06 AM the East hall medication cart was viewed with V13 Registered Nurse (RN). There were two opened vials of R47's Novolog insulin inside a single vial box that was labeled with an opened date of 3/17/25. Each bottle was not labeled with an opened date which was confirmed with V13. V13 confirmed each bottle should be labeled with an opened date. R47's April 2025 Medication Administration Record (MAR) documents R47 receives Novolog 10 units three times daily and per sliding scale three times daily. The Novolog Highlights of Prescribing Information dated February 2015 documents once opened the vial may be stored at room temperature for up to 28 days. 3.) On 4/01/25 at 9:25 AM V14 RN was passing medications on the [NAME] Hall. There were several medication cups with prepoured unidentified pills in the top drawer of the medication cart. Each medication cup was labeled with resident initials and room numbers. V14 stated V14 prepours the medications in order to administer the morning medications on time since there are a lot of residents on the [NAME] Hall. V14 confirmed this is not an acceptable practice. V14 confirmed R82's morning medications were one of the cups of prepoured medications. R82's April 2025 MAR documents R82's morning medications include Magnesium Oxide, Eliquis, Diltiazem, Atorvastatin, Calcium, Digoxin, Hydrochlorothiazide, Losartan, Meloxicam, Multivitamin and Omeprazole. On 4/2/25 at 11:42 AM V2 DON stated the nurses should not prefill medication cups prior to medication pass and V14 has been educated on this. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's pharmacy policy titled Storage of Medications, dated August 2024, documents the following: Medications are dispensed by the pharmacy and stored in the container with the pharmacy label. Medications such as injectable vials have a shorter expiration date than the manufacturer's expiration date once opened, a date opened sticker will be placed on the vial for medications with specific usable durations and used within 30 days of opening.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3.) During intermittent observations on 3/31/25 and 4/1/25 between 9:30 AM and 4:00 PM there was no Enhanced Barrier Precautions (EBP) sign posted on R38's room door and there was no cart containing personal protection near R38's room door. On 4/01/25 at 1:11 PM V48 Certified Nursing Assistant entered R38's room and removed R38's socks in order to observe R38's heel wound dressings. V48 was not wearing a gown. On 4/01/25 at 3:38 PM V8 Assistant Director of Nursing transferred R38 into bed and administered R38's sacral and heel pressure ulcer treatments without wearing a gown. V8 confirmed R38 is not on EBP. V8 stated V8 thought EBP was only needed for open wounds and indwelling devices. V8 confirmed stage two pressure ulcers are considered open wounds. R38's Wound Management Summary dated 3/18/25 documents R38's stage two sacral pressure ulcer measures 3 centimeters (cm) x 2 cm x 0.01 cm, the right heel stage two pressure ulcer measures 1 x 1.2 x 0. 01 cm, and the left heel stage two pressure ulcer measures 0.8 x 0.5 x 0.01 cm. R38's sacral wound duration was greater than 63 days. R38's Wound Management Summary dated 3/26/25 documents the sacral pressure ulcer measures 2.8 x 2 x 0.01 cm, the right heel stage two pressure ulcer measures 1 x 1.5 x 0.01 cm and the left heel stage two pressure ulcer measures 1 x 0.8 x 0.01 cm. There is no physician's order that R38 is on EBP 4.) On 4/02/25 at 11:22 AM V14 Registered Nurse applied gloves and obtained R34's blood sugar with a blood glucose meter. V14 removed gloves and placed the blood glucose meter into the top drawer of the medication cart. V14 did not perform hand hygiene before or after checking R34's blood sugar and did not disinfect the blood glucose meter after use. On 4/02/25 at 11:28 AM V14 stated there are two blood glucose meters in the medication cart and they are shared between residents on the [NAME] Hall. V14 confirmed V14 did not disinfect the blood glucose meter after use and did not perform hand hygiene before and after checking R34's blood sugar, and confirmed this should have been done. V14 stated bleach disinfect wipes should be used to disinfect the blood glucose meter. There were no bleach wipes in the medication cart, confirmed with V14. The facility's Cleaning and Sanitizing Wheelchairs and Other Medical Equipment dated 1/25/18 documents medical devices will be cleaned and sanitized between each use if shared between residents. The facility's Hand Hygiene/Handwashing policy dated 7/30/24 documents hand hygiene should be performed upon entering and leaving the resident's room, before performing aseptic tasks, after handling medical equipment, after removing gloves, and after contact with blood, body fluids, mucous membranes, non-intact skin or wound dressings. The facility's EBP policy dated 5/7/24 documents EBP is an infection control intervention used to reduce the transmission of multidrug resistant organisms by using gown and gloves during high contact resident care activities and is indicated for residents with chronic wounds. Chronic wounds includes pressure ulcers. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Failures at this level require more that one deficient practice statement. A. Based on observation, interview and record review, the facility failed to follow their Norovirus policy by failing to restrict symptomatic staff from work and handling food, and by failing to implement and follow isolation and contact precautions during a Norovirus outbreak. These failures resulted in R45 contracting Norovirus and subsequently expiring. R45's documented cause of death is listed as Acute Renal Failure related to Viral Gastroenteritis. These failures have the potential to affect all 79 residents who reside in the facility. The Immediate Jeopardy began on 3/19/25 when the facility failed to restrict V20 Dietary Aide from working with gastrointestinal virus symptoms. V1 Administrator was notified of the Immediate Jeopardy on 4/4/25 at 8:15 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 4/4/25, but noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: a. The facility's Norovirus Outbreak Measures dated 2/15/18 documents Norovirus is very resilient therefore preventative measures should be continued for at least 3 days after outbreak appears to be over. Control measures include isolation, grouping ill residents together, discontinue admissions for 7 days after onset of last known case, discontinue group activities, and post signage explaining risks of infection for residents and visitors. The Policy documents to interview each employee at the start of each shift for any symptoms of vomiting and diarrhea, exclude ill staff until asymptomatic for at least 48 hours, food staff cannot work with symptoms and are to be immediately excluded until 72 hours after last symptom. PPE (Personal Protective Equipment) of gowns and gloves should be worn by all staff, including housekeeping, and masks should be worn when providing cares for residents who are actively vomiting. The facility resident and employee infection logs document 33 residents and nine staff members with norovirus symptoms of nausea, vomiting and/or diarrhea. Logs identify V20 Dietary Aide was the first to present with symptoms on 3/19/25. The resident log includes R45 with symptom start date of 3/22/25 and R51 with symptom starting on 3/27/25. Review of employee call off forms for the dates of 3/20/25 thru 4/2/25 document a total of 10 employees who called off within that time frame. Of those 10, seven were Certified Nursing Assistants (CNAs), two were nurses and one was a dietary aide. All 10 employees reported symptoms of nausea, vomiting, fever, and/or diarrhea. On 3/31/25 at 9:10 am V3, dietary manager stated the facility is currently in Norovirus Outbreak. During intermittent observations from 3/31/25 at 8:40 am thru 4/4/25 at 10:00 am there was no signage posted at any of the facility entrances to alert staff and visitors that the facility was experiencing an outbreak of norovirus. On 3/31/25 at 11:25am R46 was seated at a main dining room table with other residents. The Progress Notes dated 3/31/25 at 5:06 am document R46 having diarrhea. The Progress Notes dated 4/4/25 document R46 is currently on contact isolation precautions related to active symptoms of nausea, vomiting, and diarrhea. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/31/25 at 12:34 PM V18, Activity Aide, was assisting with meal tray delivery to resident rooms. V18 entered R51's contact isolation room without putting on a gown or gloves. A contact isolation sign was posted at the room entrance. V18 stated I'm just an activity aide I'm not sure what resident's need what, you'll have to ask a CNA. On 04/01/25 from 10:20am thru 11:00am, V15, CNA, was giving direct resident care, changing soiled linens, collecting garbage, and disposing of soiled items for R50 inside the resident room. During this time V15 was not wearing a gown and gloves for contact isolation precautions. A contact isolation sign was posted at the room entrance with available PPE directly underneath. Upon completion of care, V15 exited the room without performing hand hygiene, and drug both the garbage and dirty linen bag on the floor to the dirty linen closet wearing only a mask. V15 did not perform hand hygiene after disposal of dirty linen and garbage bags. On 04/01/25 at 12:15 pm hall trays and drinks were distributed on the east hall. V16, CNA, entered a contact isolation room to serve a resident tray wearing only a mask stating they said I could serve trays without wearing a gown and gloves. V16 did not perform hand hygiene upon exiting the contact isolation rooms and prior to handling the next meal tray. On 4/1/25 at 12:16 AM, V6 Business Office Manager (BOM) delivered a tray into R51's room where a contact precautions sign was posted on the door. V6 did not have on a gown or gloves. V6 left the tray in the room, removed some drinking glasses off the bedside table with V6's bare hands and brought them to a cart with soiled dishware on it. V6 stated she was unaware that contact precautions were in place for R51. On 04/01/25 at 11:49 am, V20, Dietary Aide stated he had symptoms of vomiting and headache on Wednesday 3/19/25 while he was working in the kitchen and he called off for his shift the next day. At that time, he was told he could return to work in 48 hours and that there was nothing mentioned about having to be symptom free. V20 returned to working in the kitchen at 6:00 am Sunday (3/23/25), stating his last episode of vomiting occurred approximately at 10:00 am Saturday (3/22/25). On 4/3/25 at 1:57 PM, V20 stated that when he felt ill while working on the 19th, he wore gloves but nothing else. V20 also stated that when he returned to work that Sunday, he was told the facility was not in outbreak, therefore he only needed to wear gloves. V20's timecard dated 3/16/25-3/30/25 documents on 3/19/25 V20 worked 6:00 am-10:39 am and did not return until 6:00 am on 3/23/25. The Employee Call Off Form dated 3/21/25 documents V20 called off for the 3/21/25 shift with complaints of vomiting and diarrhea starting Thursday evening. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/3/25 at 9:14 AM, V31, CNA, stated her symptoms of loose stools started on Saturday 3/22/25 while working at the facility. V31 stated when she received report that morning, she was told several residents started having loose stools, nausea and vomiting the night prior (3/21/25) after eating the fish dinner served by the facility. V31 stated by Sunday everybody was sick having at least 3-4 loose stools daily. V31 stated no contact precautions were put into place that weekend but that she chose to wear a mask and gloves for resident care. V31 stated she was assigned to residents on the middle hall where at least three residents were sick with vomiting and diarrhea Saturday morning. V31 stated about four or five days later management started posting white signs indicating contact isolation outside of the rooms with residents who had been sick and during this time she was floated between all the halls to give resident care. V32 stated the facility has not provide education to staff during the outbreak. V31 stated when she called off with gastrointestinal (GI) symptoms, she was told by V2, DON, that she had to be off for 48 hours before returning to work, however she wasn't clear so she followed up with V41, Human Resources Director (HR) who told her she could return to work 24 hours after becoming asymptomatic. V31 returned to work 3/26/25 at 6:00 am, but states she started feeling really sick, having stomach pain and vomiting again yesterday (4/2/25) while at work, and was ultimately sent home and told she could return to work on Saturday (4/5/25). V31's Employee Call Off Form documents the reason for call off on 3/22/25 was GI/diarrhea. V31's Employee Call Off Form documents the reason for call off on 4/2/25 was V31 reported vomiting. On 4/3/25 at 1:15 PM, V37, CNA, stated that she had GI symptoms that started about one to one and a half weeks ago. V37 stated her stomach started to hurt, she had diarrhea and started to feel dizzy while she was at work. V37 stated that she wore gloves and a mask but no gowns while she was experiencing symptoms. They told me I just had to be off for 48 hours prior to returning to work and did not mention that V37 had to be symptom free for 48 hours before returning to work. V37's employee call off form documents the reason for call off on 3/29/25 was nausea and vomiting. On 4/3/25 at 10:40am, V21, RN, stated on 3/21/25 everyone was sick, and the facility continued to receive new admissions. V21 stated she received an admission on [DATE] (R56) and another on 3/25/25 (R14) and both residents were having GI symptoms within 12-24 hours of admission. V21 also stated management insisted on floating CNAs between halls of sick and well residents. V21 stated that just this morning (4/3/25) they attempted to tell the mid-hall CNA to float between there and east-hall. East-hall has the most recent symptomatic residents and mid-hall residents have already resolved GI symptoms. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04/01/25 at 9:15 am V8, Assistant Director of Nursing/ Infection Preventionist (ADON/IP), stated the facility tracks and trends all infections for residents and employees on a log. V8 stated when a resident is on contact isolation anyone entering the room must put on a gown and gloves even if they aren't providing cares. It is also recommended that the residents stay in their room until symptom free for 48 hours. V8 stated she notified the County Health Department on March 24, 2025, of the Gastrointestinal Virus Infection outbreak. At 12:55 pm on 4/1/25, V8, Assistant Director of Nursing/ Infection Preventionist (ADON/IP), stated historically the housekeeping supervisor had been responsible for educating staff about isolation precautions and appropriate personal protective equipment. V8 stated the facility is aware that they are having issues regarding staff not wearing appropriate PPE and following isolation precautions this week. On 4/3/25 at 10:00am, V8 stated the dates recorded on the employee illness log for the start of symptoms are the dates the employee called off from their scheduled shift, and that she had not personally spoken to any of the employees to identify what symptoms they were having and the date of onset. V8 confirmed staff did not report to her at the beginning of the outbreak, which lead to delay in isolation precautions being implemented for four days. On 4/3/25 at 11:45 am, V8 stated she was not aware the norovirus policy stated employees must be interviewed about symptoms before each shift during active outbreak and was unclear who would be responsible for doing that. On 4/3/25 at 3:15 pm, V22 [NAME] President of Operations stated employees should be asymptomatic for at least 48 hours prior to returning to work, and all dietary staff at least 72 hours prior. V22 confirmed the facility's Norovirus policy was not being followed. R45's progress notes document date of discharge from the facility as 3/26/25 with R45 being discharged to a funeral home. R45's Death Certificate dated 3/28/25 signed by V30, Facility Medical Director, documents R45's cause of death as Acute Renal Failure related to Viral Gastroenteritis. R45's Nurse Practitioner visit notes dated 8/14/24 document a past history of chronic kidney disease resolved in October of 2021 by Urologist with urology sign off and there have been no kidney issues since. On 3/24/25 at 5:54 AM, V33, Licensed Practical Nurse (LPN), documented in R45's Medication Administration Record Progress Notes that she held R45's scheduled 6:00 AM dose of acetaminophen related to R45 vomiting. The Progress Notes dated 3/24/25 at 12:10 PM by V27, Registered Nurse (RN) document that R45 was assessed for GI symptoms and vital signs due to GI illness going around the facility. Resident's temperature 101.5 degrees Fahrenheit (F) and V30, Medical Director, and R45's POA were notified. New orders received for anti-nausea medications and to start an intravenous (IV) line and give 2 liters of Lactated Ringers (LR) intravenous (IV) solution. The Progress Notes dated 3/24/25 at 6:36 PM by V27 state R45 has IV fluids infusing, more lethargic with current temperature of 102.5 F, V30 updated, and order received to send R45 to the emergency department. The Visit Note dated 3/24/25 at 10:01pm by V30 documents R45 has symptoms of nausea, multiple episodes of vomiting after meals, diarrhea and tested positive for Norovirus. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R45's Progress Note dated 3/25/25 at 12:23 PM documents R45 returned to the facility with oxygen 2 liters (L) nasal cannula (NC) with a new order for antibiotic related to a possible urinary tract infection and that V30 was notified of R45's return. R45's Progress Note dated 3/26/25 at 3:00 AM documents R45 was found unresponsive in room at 1:55 AM and pronounced deceased . On 4/3/25 at 10:20 am, V27 Registered Nurse (RN), stated on 3/24/25 V27 received report that several residents in the facility were having GI symptoms and that R45 had started vomiting throughout the night. Upon assessment of R45, V27 stated R45 had a temperature of 101.5 degrees Fahrenheit and appeared more fatigued than his baseline. V27 indicated R45 was mostly non-verbal at baseline and moderate to maximum assistance for all care but was not a sickly person, never had any urinary issues and no recent illnesses. V27 stated V30 was notified of the fever and gave orders for anti-nausea medications and to start an intravenous (IV) line and give 2 liters of Lactated Ringers (LR) IV solution. V27 stated that after about 250 milliliters of LR had infused, R45's temperature increased to over 102 and his level of consciousness (LOC) decreased. V27 stated she notified V30 and R45 was sent to the local emergency department but was quickly returned with an order for antibiotic and diagnosis of urinary tract infection but no documentation of any labs or cultures performed. On 4/3/25 at 9:52 am V30, Medical Director (MD) stated he was first informed of the facility's norovirus outbreak on Monday 3/24/25 and was told that 6-7 residents had GI symptoms including headache, fever, nausea, vomiting, and diarrhea within the last 24 hours. At that time, V30 stated he was working with the floor nurses to provide residents with acetaminophen for symptoms of headache and fever, anti-nausea medications for nausea and vomiting and IV hydration to counter dehydration. V30 stated he also ordered laboratory testing for influenza, COVID-19 and norovirus. V30 stated later that same day V27, RN, called with concerns about R45 not responding to any of the treatments and R45's fever had increased from 101.5 degrees Fahrenheit to now over 102 degrees Fahrenheit (F) and that R45's level of consciousness had declined. V30 ordered to send R45 to the emergency department for evaluation and treatment. V30 stated it is unclear as to why R45 was sent back to the facility so quickly and unfortunately R45 passed away not long after. V30 confirmed that on 3/28/25 he personally filled out and signed R45's death certificate documenting R45's cause of death as Acute Renal Failure due to Viral Gastroenteritis. V30 stated R45 had a history of hypertensive renal failure but that was resolved in October 2021 by the urologist and R45 had not had any further issues. V30 confirmed R45's last laboratory values completed on 3/3/25 indicated R45 had normal renal function. V30 stated R45 would have lived much longer without contracting Norovirus. The facilities Long-Term Care Facility Application for Medicare and Medicaid dated 03/31/25 indicates that there are 79 residents that reside in the facility. The facility presented an abatement plan to remove the immediacy on 4/4/25 at 10:35 AM and presented revision of the abatement plan on 4/4/25 at 11:00 AM, 11:15 AM, 11:45 AM, and 12:51 PM. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions on 4/4/25 at 10:50 AM, 11:04 AM, 11:43 AM, 12:20 PM, and 12:57 PM. The facility presented a revised abatement plan on 4/4/25 at 1:08 PM and the survey team accepted the abatement plan on 4/4/25 at 1:19 PM. The Immediate Jeopardy that began on 3/19/25 was removed on 4/4/25 when the facility took the following actions to remove the immediacy: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1.) Infection Preventionist, Director of Nursing and Administrator were educated by the Regional Nurse Consultant on 4/3/25 on the facility's Norovirus - Outbreak Measures Policy including but not limited to Isolate all ill residents from others by encouraging residents to remain in their room until symptom free for 48 hours after last symptom of vomiting or diarrhea, post signs explaining the risk of infection of ill patients and ill visitors, interview each employee at the start of their shift regarding vomiting and diarrhea, exclude ill staff until asymptomatic for at least 72 hours after cessation of symptoms, and staff should wash hands when entering and leaving every resident room with soap and water, and wash hands thoroughly and often during the outbreak - DO NOT use alcohol based hand sanitizers. 2.) All staff were educated on the facility's Norovirus - Outbreak Measures Policy including but not limited to Isolate all Ill residents from others by encouraging residents to remain In their room until symptom free for 48 hours after last symptom of vomiting or diarrhea, post signs explaining the risk of Infection of Ill patients and ill visitors, interview each employee at the start of their shift regarding vomiting and diarrhea, exclude Ill staff until asymptomatic for at least 72 hours after cessation of symptoms, and staff should wash hands when entering and leaving every resident room with soap and water, and wash hands thoroughly and often during the outbreak - DO NOT use alcohol based hand sanitizers by the Infection Preventionist, Director of Nursing and Administrator on 04/03/2025. Staff members who are on FMLA (Family Medical Leave of Absence) or vacation and all agency staff will be in-service prior to returning to the facility by the Infection Preventionist/Director of Nursing/ Designee or Administrator. 3.) The Infection Preventionist, Director of Nursing and Administrator were educated on the facility's Infection Precaution Guidelines including but not limited to standard precautions and transmission-based precautions including precautions needed, duration of precautions, and type of PPE that is required for each contact precautions, droplet precautions and airborne precautions. Hand hygiene, gather all equipment and supplies needed before going into the room and only take needed supplies into the room. All personal protective equipment (PPE) should be used once and discarded in either the trash or used linen receptacle before leaving the room, and precaution signs will be utilized to alert staff and visitors to see the nurse for instructions prior to entering the room by the Regional Nurse Consultant on 4/3/25. 4.) All staff were educated on the facility's Infection Precaution Guidelines including but not limited to standard precautions and transmission-based precautions including precautions needed, duration of precautions, and type of PPE that is required for each contact precautions, droplet precautions and airborne precautions. Hand hygiene, gather all equipment and supplies needed before going into the room and only take needed supplies into the room. All personal protective equipment (PPE) should be used once and discarded in either the trash or used linen receptacle before leaving the room, and precaution signs will be utilized to alert staff and visitors to see the nurse for instructions prior to entering the room by the Infection Preventionist, Director of Nursing and Administrator on 04/03/2025. Staff members who are on FMLA or vacation and all agency staff will be In-serviced prior to returning to the facility by the Infection Preventionist, Director of Nursing/Designee, or Administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145183	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Danville	620 Warrington Avenue Danville, IL 61832

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	5.) All staff were educated on the facility's Hand Hygiene Policy including but not limited to when to wash hands with soap and water-when hands are visibly dirty and after known or suspected exposure to Clostridium difficile, or after known or suspected exposure to patients with infectious diarrhea during norovirus outbreaks and the procedure for using alcohol-based hand sanitizer and washing hands with soap and water by the Infection Preventionist, Director of Nursing and Administrator on 04/03/2025. Staff members who are on FMLA or vacation and all agency staff will be in-serviced prior to returning to the facility by the Director of Nursing/Designee or Administrator. 6.) All staff were educated on the facility's Infection Control - Determining PPE Needs Policy including but not limited to type of personal protective equipment (PPE) used in different situations and each situation may be evaluated on an individual basis to determine the level of risk associated and may be determined to require more or less protective equipment by the Infection Preventionist, Director of Nursing and Administrator on 04/03/2025. Staff members who are on FMLA or vacation and all agency staff will be in-serviced prior to returning to the facility by the Director of Nursing/Designee or Administrator. 7.) Notification of Norovirus outbreak has been posted at all facility entrances on 4/4/25 by Administrator. 8.) A communication log will be utilized and updated at least every 24 hours to communicate the new infectious symptoms to staff to ensure awareness of all communicable diseases. Communication logs will be placed at each nurse's station and dietary department. Infectious Symptoms for Communication log will be updated by the Infection Preventionist or Director of Nursing. Staff were educated on the Communication log to communicate new infectious symptoms for current residents on communicable diseases by Infection Preventionist /Director Nursing and Administrator on 4/4/2025. 9.) All management staff were educated on reporting timely all employee illnesses to Infection Preventionist or Director of Nursing by RNC on 4/3/25. 10.) IDPH Infection Control Coordinator was contacted by [NAME] President of Operations on 4/4/25 for Infection Control and Outbreak Consulting with tentative visit on 4/22/2025. 11.) An impromptu QAPI (Quality Assurance Performance Improvement) meeting was held with the medical director and staff IDT (Interdisciplinary Team) team on 4/4/25 to discuss deficiency and facility action plan. 12.) The facility has started (4/4/25) and will continue to conduct audits (7 days per week for 6 weeks) to ensure staff are conducting hand hygiene, donning/doffing PPE, staff are interviewed prior to shift regarding vomiting/diarrhea, and staff with symptoms do not return to work until 72 hours have passed since last symptom. A QA tool will be completed to verify this practice has occurred. The QA tool will be completed by infection Preventionist/DON or designee, daily for 6 weeks. There will be oversight of the QA tool by RNC. (continued on next page)

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