STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl Pavilion	900 South Kiwanis Drive Freeport, IL 61032

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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 ensure resident dignity by not applying a privacy covering to a urinary catheter bag for 1 of 18 residents (R22) reviewed for dignity in the sample of 18. The findings include:On 11/18/25 at 11:09 AM, V22, Certified Nursing Assistant (CNA) and V23 (CNA) got R22 into a chair. R22's urinary catheter bag was hung on the side of R22's wheelchair and it did not have a privacy covering on. R22 was brought to the dining room and placed at a table. There were other residents in the dining room waiting for lunch to be served. On 11/18/25 at 1:04 PM, R22 was lying in bed. R22's urinary catheter bag was hanging on the side of her bed with no privacy covering present and the bag could be seen from the hallway. On 11/18/25 at 1:13 PM, V12 (CNA) said that all urinary catheter bags should have a courtesy (dignity) bag on them for the resident's privacy especially if they are in the dining room or public areas. On 11/19/25 at 12:13 PM, V2 (Director of Nursing) said that all urinary catheter bags should have a dignity bag applied if they are outside of their room or if the bag can be seen from the hallway. V2 said that the dignity bags are used to provide the resident with dignity and privacy. The facility's Dignity Policy shows, Examples of promoting dignity and respect include, but are not limited to: Using privacy coverings for urinary catheter bags .

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident was safe to self-administer medications for 1 of 18 residents (R66) reviewed for self-administration in the sample of 18. The findings include:R66's Face Sheet shows that he admitted to the facility on [DATE] with diagnoses of: Alzheimer's disease, dementia, chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, schizoaffective disorder, chronic hepatic failure, scoliosis and pneumonia.On 11/17/25 at 9:54 AM, R66 had an albuterol inhaler, fluticasone inhaler, beet root 1000 milligram supplement and diclofenac cream on a table in his room. R66 said that he takes the albuterol inhaler when needed, the fluticasone inhaler twice a day, the beet root daily and uses the diclofenac cream when he has pain in his head and neck. R66's Physician's Order Sheet (POS) printed on 11/17/25 shows an order for albuterol inhaler-2 puffs every 6 hours as needed for shortness of breath, fluticasone inhaler-one puff one time a day for shortness of breath and diclofenac cream-apply to back every 12 hours as needed for arthritis pain. R66's POS does not document that he is taking beet root. R66's POS does not document an order to self-administer any medications. On 11/18/25 at 2:45 PM, V11 (Registered Nurse) said that if a resident wants to self-administer a medication, they would need an order for the medication and they would need an order from the physician to be able to self-administer. On 11/19/25 at 12:13 PM, V2 (Director of Nursing) said that if a resident wants to self-administer medications, the facility has to do an assessment to ensure that it is safe and the physician has to approve it. V2 said that R66 does not have an assessment or an order for self-administration of medications.R66's Care Plan does not document that he is able to self-administer medications. The facility's Self-Administration of Medications Procedure shows, Residents who request to self-administer drugs will be assessed at the time of admission or thereafter, to determine if the practice is safe. This will include documentation when medications are used. The assessment results will be discussed with the attending physician and an order obtained to self-administer, if appropriate.Drugs in the room should be written on the medication record as may keep at bedside and the expiration date.A care plan indicates that resident's self-administering of medications.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their advanced directives policy by not obtaining an order for Do Not Resuscitate (DNR) for 1 of 18 residents (R66) reviewed for advanced directives in the sample of 18. The findings include:R66's Face Sheet shows that he admitted to the facility on [DATE].R66's Do-Not Resuscitate (DNR)/Practitioner Orders for Life-Sustaining Treatment (POLST) Form dated 4/23/18 shows that he does not want cardiopulmonary resuscitation attempted. R66's Physician's Order Sheet printed on 11/17/25 does not document an order for DNR. On 11/18/25 at 2:45 PM, V11 (Registered Nurse) said that typically social services speaks with the resident upon admission on if they would like to be a full code or DNR. V11 said that if they would like to be a DNR, a form has to be filled out and signed by the resident and physician. V11 said that once the form is signed, an order is placed in the electronic medical record for DNR. V11 said that the resident's code status shows on the information bar in the computer system. V11 said if a resident was to code, she would check the information bar to determine if she would start resuscitation or not. V11 reviewed R66's electronic medical record and looked at his information bar and said, Yeah, he doesn't have anything on the information bar and does not have an order so I am not sure what I would do. The facility's Advanced Directive Life Sustaining Treatment and End of Live Care Policy and Procedure shows, It is the policy of this healthcare facility to assure residents and their families have the right .to formulate advance directives including Do Not Resuscitate orders (DNR) Staff are responsible for following this policy/procedure and honoring the individual's advance directive choices An Advance Directive form (as provided by healthcare facility) will be completed with resident and/or legal representative to verify treatment options as well as code status (full code vs. DNR using POLST document). Appropriate information will be added to the Physician Order Sheet (POS).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents with new diagnoses of mental health disorders were referred to the state designated authority. This applies to 4 of 4 (R9, R4, R6, R68) residents reviewed for pre-admission screening and resident reviews (PASRRs) in the sample of 18. The findings include:1. R9's Facesheet dated 11/18/25 shows R9 was admitted to the facility on [DATE]. R9's Facesheet shows R9 had the following mental health diagnoses upon admission: anxiety disorder, mild intellectual disabilities, and mild cognitive impairment. R9's OBRA-I (Omnibus Budget Reconciliation Act) Initial Screen dated 10/16/15 shows there were no suspicions of Developmental Disability or Mental Illness for R9. R9's psychiatry progress note dated 4/30/19 shows R9 has the following diagnoses: bipolar disorder (unchanged), generalized anxiety disorder (unchanged), major depressive disorder (unchanged), and insomnia (new). R9's Psychiatry note dated 12/14/19 shows staff report R9 having aggressive behavior, impulsivity, and mood swings. Progress note also states to start quetiapine (antipsychotic medication) BID (twice daily) and monitor. On 11/18/25 at 2:00 PM, V6 (Liaison) said she currently does the preadmission screening and resident review (PASRR) and has been doing them for about a year. V6 said until 11/18/25, V6 was not aware that the PASRR had to be redone with a new diagnosis of mental illness. On 11/19/25 at 12:32 PM, V6 said the facility should have sent a referral to the state designated authority to ensure R9 did not require additional services and R9's placement in the facility was appropriate. 2. R4's face sheet shows, she was admitted to the facility on [DATE]. The same form shows, a new diagnosis of schizophrenia was added on 10/2/2023. R4's original interagency certification of screening results (OBRA screen) dated 2/6/2018 do not show she has a mental illness. There is no updated PASRR or OBRA for R4 following the addition of schizophrenia diagnosis. On 11/19/25 at 12:31 PM, V6 facility liaison stated, through an audit the night before she saw R4 had a diagnosis of schizophrenia added in 2023 (2 years ago) and her PASRR was never updated/requested. 3. R6's face sheet shows, he was admitted to the facility on [DATE]. The same form shows, a new diagnosis of major depressive disorder on 8/22/2023 and schizoaffective disorder, bipolar type on 4/20/2019. R6's original interagency certification screening results (OBRA screen) dated 4/16/2018 does not show he has a mental illness. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There is no updated PASRR or OBRA for R6 following the addition of major depressive disorder or schizoaffective disorder diagnoses. On 11/19/25 at 12:31 PM, V6 facility liaison stated, through an audit the night before she saw R6 had a new diagnosis added in 2023 (2 years ago) and a new PASRR was never updated/requested. 4. R68's face sheet shows, she was admitted to the facility on [DATE]. The same form shows, a new diagnosis of major depressive disorder on 9/27/2022. R68's interagency certification screening results (OBRA screen) dated 4/19/2010 does not show she has any mental health illness. There is no updated PASRR or OBRA for R68 following the addition of major depressive disorder diagnosis. On 11/19/25 at 12:31 PM, V6 facility liaison stated, through an audit the night before she saw R68 had a new diagnosis added in 2022 and a new PASRR was never updated/requested. The facility's Pre-admission Screening and Resident Review (PASRR) policy dated 12/2023 does not show the updated guidance to ensure facility's are updating PASRR's when changes to diagnoses that fit the criteria.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that required Preadmission Screening and Resident Review (PASARR) Level I screening reflected a resident's possible/suspected developmental disability. This applies to 1 of 5 residents (R10) reviewed for PASARR in the sample of 18. The findings include:On 11/18/25 at 8:18 AM, R10 was laying in bed. She was very childlike and stated, This is a nursing home, I don't want to stay here forever, I'm only 33. She continued to state, she lived in an apartment by herself and had some health issues which sent her to the hospital. She ended up at the facility. She didn't know why she was there. R10's face sheet shows her diagnoses as dehydration, dizziness and giddiness and adult failure to thrive. Her electronic medical record shows, she has no scheduled medication and is independent with all of her personal care. R10's emergency room documentation dated 9/3/25 shows, [AGE] year old with a reported past medical history of developmental delay brought by local police for medical evaluation after a well being check. The same documentation continues to show, Patient previously homeless living in a assisted apartment typed facility in our community now had a welfare check which revealed unlivable living conditions. Patient does not have a lot of complaints today is eating 2 large meals since she arrived here. She has no family. She has no ability to work she seems to have some sort of developmental delay and acts significantly younger than her stated age. R10's progress noted dated 9/11/25 shows, [AGE] year old female with history of developmental delay/mild cognitive impairment presents for admission to nursing home. R10's notice of PASRR Level I Screen Outcome dated, 9/4/25 shows, PASRR Level I Determination: No Level II required- No SMI (serious mental illness)/ID (intellectual disability)/RC (related condition). The same form continues to show, Does the individual have a diagnosis of an intellectual disability? No. Is the individual suspected to have an intellectual disability that has not been diagnosed? No. The form does not reflect the ER physician documentation showing, she has a history of a developmental disability and/or observations made of resident showing she significantly acts younger than her stated age. On 11/18/25 at 12:42 PM, V6 facility liaison stated, she was admitted for a short term stay. V6 is the one who handles the PASRR's. The hospital did R10's PASRR. They have not done anything else with it. The PASRR showed she was eligible to come to the facility so they did not question anything further. The facility's Pre-admission Screening and Resident Review (PASRR) policy dated 12/2023 shows, Background: In accordance with Federal and State of Illinois regulatory standards and recommended practices, this organization requires each resident to be screened for Level 1 prior to or shortly thereafter admission (e.g., post-screen for someone out of state or coming from home). The facility will expect Maximus to properly complete the Level 2 if a PASRR condition (SMI/ID) exists. Policy: 3. Review the PASRR documents to help assess/ascertain what type of problems, needs and issues need to be addressed to help the resident function at his/her maximum level of well-being.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who requires assistance with activities of daily living received assistance with showers. This applies to 1 of 18 residents (R54) reviewed for activities of daily living in the sample of 18. The findings include: R54's face sheet shows he was admitted to the facility on [DATE] with diagnoses including history of falling, pneumonia, myocardial infarction type 2, and nonrheumatic aortic valve stenosis. On 11/17/25 at 9:55 AM, R54 was in his room sitting on his bed. R54 said he came here from the hospital with pneumonia and is weak. He is not strong enough to walk and stand on his own. R54's hair was disheveled, unkempt, and oily. R54's facial hair was overgrown and scruffy, he said he has not had a shower since being at the facility and no one has offered him a shower. On 11/18/25 at 9:15 AM, R54 was in his room his hair remained disheveled, unkept and oily. He said he has not been offered a shower yet. On 11/18/25 at 1:10 PM, V12 (Certified Nursing Assistant-CNA) said residents should receive weekly showers at least one a week. There is shower schedule to show shower days for the residents. R54 requires staff assistance with showers, she is not sure when he had a shower. The facility's shower schedule shows R54's shower days are on Tuesdays. R54's shower sheets dated 11/6/25 shows he refused his shower. R54's shower sheet shows he was offered a shower on 11/18/25 (12 days later). On 11/19/25 at 9:59 AM, V1 (Administrator) said residents should receive showers weekly and confirmed R54 was not provided a weekly shower. The facility's Activities of Daily Living Policy dated 2025 states, to preserve activities of daily function, promote independence, and increase self-esteem and dignity. The policy does not include the frequency of showers.

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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 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. Based on observation, interview and record review the facility failed to ensure pressure ulcer prevention interventions were in place for at risk residents for 2 of 4 residents (R22 and R59) reviewed for pressure ulcers in the sample of 18.The findings include:1. R22's Braden Scale dated 10/10/25 shows that she is at risk for developing pressure ulcers. R22's Wound Physician Notes dated 11/17/25 shows that she has pressure ulcers on her right lateral proximal leg measuring 0.3 centimeters (cm) x 0.5 cm x 0.1 cm, left lateral leg/ankle measuring 1.0 cm x 0.5 cm x 0.3 cm and medial 1st metatarsal of left foot measuring 0.9 cm x 0.7 cm x 0.2 cm. R22's November Monthly Weights Report shows that she weighs 144.2 pounds. R22's Physician's Order sheet shows an order dated 9/24/25 for, Apply heel protectors to bilateral heels while in bed for pressure off-loading. On 11/17/25 at 11:09 AM, R22 was lying in bed. R22 had an air mattress. R22's air mattress had a fitting sheet over it. R22's air mattress was set to firm, normal pressure. R22 had a heel protector boot on her left heel. R22 was assisted up to her high back wheelchair and wheeled to the dining room and only had a left heel protector boot on. On 11/18/25 at 1:01 PM, R22 was lying in bed. R22's air mattress had a fitted sheet on it and was still set to firm, normal pressure. On 11/18/25 at 1:40 PM, V13 (Wound Care Nurse) said that R22 currently has three pressure ulcers. V13 said that pressure ulcer preventative measures put in place for R22 include: heel protector boots on both of her feet, repositioning and an air mattress. V13 said that air mattresses are set up by maintenance when they arrive and should be set to the appropriate settings. V13 said that if it is a mattress that goes by the resident's weight, it should be set to the appropriate weight. V13 said that fitted sheets are not to be used on air mattresses because the mattress will not be able to circulate and proportion the air the appropriate way. R22's Care Plan shows that she is at increased risk for alteration in skin integrity related to multiple pressure injuries, incontinence-associated dermatitis, deep tissue injuries to bilateral feet heels, and knees, significant knee contractures affecting mobility and positioning, presence of an indwelling urinary catheter, feeding tube and overall impaired healing potential. R22's Care Plan show interventions of: Reposition resident every 2 hours and as needed to off-load pressure from sacrum, heels, and bony prominences; use pillows, heel protectors, and specialty mattress as appropriate . 2. R59's Braden Scale dated 10/10/25 shows that she is at risk for developing pressure ulcers. R59's Physician's Order Sheet shows an order dated 8/26/24 for, Pressure reduction mattress. R59's November Monthly Weights Report shows that she weighs 186 pounds. On 11/17/25 at 9:52 AM, R59 was lying in bed sleeping. R59 had an air mattress. R59's air mattress had a fitted sheet on it and the air mattress weight setting was set to max-400 pounds. At 12:12 PM, R59 was still lying in bed and still had a fitted sheet on and her air mattress was still set to max. On 11/18/25 at 1:13 PM, V12 (Certified Nursing Assistant) said that air mattresses are set up by maintenance, and the CNAs do not have to adjust any of the settings. V12 said that fitted sheets can be used with the air mattresses as long as they fit. R59's Care Plan shows she has an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues related to impaired cognition, incontinence and failure to thrive. R59's interventions include: Pressure reducing/relieving mattress and W/C cushion as needed. The Operator's Manual for the air mattress shows, You may place a thin cotton sheet over the quilted mattress top cover Patients can directly lie on the mattress or cover with a sheet and tuck loosely to increase comfort of the patient Determine the patient's weight and set the control knob to that weight setting on the control unit. The facility's Wound Policy shows, Identified risk factors should be discussed in CAA documentation and addressed in the Resident's care plan to assure appropriate interventions to manage the risk are implemented.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident 's walkway path in her room was free from accidental hazards this applies to 1 of 18 residents (R8) in the sample of 18. This failure resulted in R8 tripping in her cluttered room and sustaining a left ankle and foot fracture. The findings include: On 11/17/25 at 9:40 AM, R8 was in her room sitting in her wheelchair. An immobilizer boot was in place to her left lower leg. R8 said about a month ago, she was in her room and her roommate had four visitors in the room. The visitors were sitting in chairs across her roommate's bed and she was trying to walk through the small space with her walker tripped and fell. R8 said there was not enough walk space causing her to trip and fall. R8 said she had a left ankle fracture and is non-weight bearing to her left leg. On 11/18/25 at 10:44 AM, V10 (Licensed Practical Nurse-LPN) said she was R8's nurse when she fell on [DATE]. R8 was in her room walking with her walker. Her roommate had several visitors visiting and the visitors were sitting across R8's roommate's bed. R8 was walking with her walker trying to get through the space and she tripped and fell. The room was overcrowded and there was not enough walk space for R8 to get through. On 11/19/25 at 8:39 AM, V2 (Director of Nursing) said R8 tripped and fell in her room due to safety hazards. R8's walk space was limited and there were several visitors in the room at that time. Walkways should be free of clutter and have enough space for a resident to walk. V2 said R8 sustained a left ankle fracture but did not require surgical intervention. R8's Fall Risk Review dated 9/20/25 shows she is at moderate risk for falls due to history of falls in the last three months, balance problems when walking and use of assistive device. R8's Fall Incident Report dated 10/5/25 shows (R8) tripped in her room trying walk past visitors . predisposing environmental factors include crowding people crowded in room, several chairs in room (R8) was sent to out to the local hospital and diagnosed with a fracture R8's Hospital Discharge report dated 10/6/25 shows fracture of distal fibula and fracture of third metatarsal bone of left foot. R8's current care plan shows she is at risk for falls with interventions including proper footwear, use of walker, call light within reach and encourage her to use of assistance. R8's care plan does include ensuring her room is free from safety hazards and clutter. The facility's Safety and Supervision of Residents Policy revised 2025 states, Our facility strives to make the environment as free from accidental hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review the facility failed to ensure a resident's indwelling urinary catheter drainage tubing and drainage bag was positioned to prevent from touching the floor for a resident with a history of urinary tract infection. This applies to 1 of 3 residents (R44) reviewed for indwelling catheters in the sample of 18. The findings include:R44's face sheet shows he has diagnoses including multiple sclerosis, hypertension, neuromuscular dysfunction of bladder and emphysema. On 11/17/25 at 3:50 PM, R44 was in the hallway self-propelling in his wheelchair. R44's indwelling catheter tubing and urinary drainage bag was dragging on the floor underneath his wheelchair. On 11/18/25 at 9:17 AM, R44 was in his room sitting in his wheelchair. R44's dignity bag was loosely secured to the back of his wheelchair with the urinary drainage tubing and drainage bag resting on the floor under his wheelchair. On 11/18/25 at 12:57 PM, V11 (Registered Nurse-RN) said R44 has indwelling catheter and was treated for urinary tract infection this month. On 11/18/25 at 1:10 PM, V12 (Certified Nursing Assistant-CNA) said indwelling urinary drainage bags and tubing should be off the floor. R44's indwelling tubing can drag on the floor she had to secure the dignity bag straps to his wheelchair this morning because it was not secured. The facility's Catheter Care Policy states, The facility staff will follow the best practice in performing catheter care. To establish guidelines to reduce the risk of, or prevent infections in residents with an indwelling catheter.urinary drainage bags and tubing shall be positioned to prevent them from touching the floor.

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Pearl Pavilion	900 South Kiwanis Drive Freeport, IL 61032

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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 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 ensure a resident had orders for oxygen administration and failed to ensure tubing was changed and humidifiers were monitored for 2 of 2 residents (R66 and R50) reviewed for oxygen in sample of 18. The findings include:1. R66's Face Sheet shows that he admitted to the facility on [DATE] with diagnosis of: chronic respiratory failure with hypercapnia and hypoxia, chronic obstructive pulmonary disease and pneumonia. On 11/17/25 at 9:54 AM, R66 was lying in bed with oxygen being administered via a nasal cannula. The oxygen tubing was attached to an oxygen concentrator and set to 2.5 liters. R66's oxygen tubing was dated 10/27/25. R66 had a portable oxygen tank in his room, and the oxygen tubing was dated 11/4/25. On 11/18/25 at 2:45 PM, V11 (Registered Nurse) said that all oxygen administration needs to be ordered by the physician. V11 said that oxygen tubing is changed weekly and is documented on the Medication Administration Record. R66's Physician's Order Sheet printed on 11/17/25 does not show an order for oxygen administration or oxygen tubing changes. The facility's Oxygen Administration and Storage Policy show, The nurse will call the physician as soon as reasonable to obtain a physician's order Tubing should be changed weekly. Nasal cannula tubing may need to be changed more frequently Procedure: Verify physician's order for procedure .Turn on oxygen and set flow rate to prescribed amount 2. On 11/17/25 at 10:48 AM, R50 was lying in bed with her oxygen nasal cannula draped across her chest and not adorned properly. R50 said she removed the nasal cannula and forgot to replace it. R50 was out of breath while being interviewed by this surveyor. At 11:12 AM, R50 self-administered an inhaler two times to help catch her breath. On 11/17/25 at 11:03 AM, R50's oxygen concentrator was on and running. The humidifying jar did not contain any water. Behind the oxygen concentrator was a half full plastic container of water. On 11/17/25 at 1:28 PM, R50's oxygen concentrator was running, and the humidifying jar was now filled with water. R50 was wearing her nasal cannula and mentioned she could tell the oxygen was working much better now that there was water in the humidifying jar. On 11/19/25 at 10:48 AM, V24 (LPN-Licensed Practical Nurse) said she would usually check the water in the oxygen humidifying jar any time she enters a resident's room that uses oxygen. If she notices that the water is low or out, V24 would change the water instantly. V24 also said if other direct care staff noticed the humidifying jar was low or out of water, V24 would expect the direct care staff to notify the nurse on duty so it could be refilled. V24 said only a nurse could fill the water on the oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/25 at 12:13 PM, V5 (Assistant Director of Nursing- ADON) said oxygen humidifying jars are checked by nurses any time they enter a resident's room and look at the resident. Humidifying jars should not be empty, and they should be refilled if empty. Humidifying jars are used on oxygen concentrators because oxygen can be drying and a humidifying jar prevents the nasal passages from drying out. Facility provided Oxygen Administration and Storage policy dated 1/1/22 states, . 13. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure hand hygiene was completed to prevent cross-contamination, kitchen equipment was cleaned, sanitized, and covered, and failed to ensure a thermometer was cleaned and sanitized before continued use. This has the potential to effect all residents receiving food from the kitchen. The findings include: Centers for Medicare and Medicaid Services 671 dated 11/17/25 shows there are 68 residents in the facility. Facility provided diet report shows there are 2 residents that are on a nothing by mouth (NPO) diet order and do not receive food from the kitchen. 1. On 11/17/25 at 10:07 AM, V16 (Cook) began removing raw chicken leg quarters from a box and placing them on a full size sheet pan while wearing a pair of gloves. At 10:09 AM, V16 used both gloved hands to handle the raw chicken. Immediately after handling the raw chicken, while wearing the same gloves, V16 grabbed a container of seasoning and began seasoning the chicken. At 10:11 AM, while still wearing the same gloves, V16 proceeded to reach under the prep table to grab another sheet pan and sprayed it with cooking spray. After spraying the pan with cooking spray, V16 removed the soiled gloves and washed her hands. On 11/18/25 at 10:13 AM, V14 (Food Service Director) said when food service staff use gloves, staff should discard and replace gloves when changing tasks or going from handling food to grabbing objects. V14 said hand hygiene is a top focus for food safety in order to prevent cross-contamination. Facility Food Safety and Sanitation Handwashing Policy, dated 9/21/23 states, Employees are required to wash hands: . before and after handling raw meat, poultry and seafood . 2. 11/17/25 at 11:47 AM, V15 (Cook) grabbed a thermometer from the prep table and began taking the temperature of the foods on the service line. V15 started with the steamed vegetables. When finished, V15 took the thermometer to the sink adjacent the steam table and ran the thermometer under water. V15 immediately went back to the service line and took the temperature of the diced potatoes. V15 then again returned to the sink and ran the thermometer under water. V15 then immediately went back to the service line and continued this process until the temperatures were finished. There were no thermometer probe sanitizing wipes on the prep table. On 11/18/25 at 10:13 AM, V14 said staff should be sanitizing the thermometer between dissimilar products by either using a sanitizing rag or a thermometer probe sanitizing wipe. 3. On 11/17/25 at 10:05 AM, the meat slicer that was on the prep counter adjacent the stove was not covered and it had caked on food debris behind the blade and on the housing behind the blade. There was a hex key screw head in the center of the front of the blade, holding the blade onto the meat slicer. On 11/17/25 at 10:05 AM, V14 said he was not sure if the blade was removable to clean and the machine did not come with a specific cover to cover the equipment. Facility Food Safety and Sanitation General Preparation and Cooking Practices policy, dated 9/18/25 states, The facility will follow sanitary practices in food preparation and cooking to keep food safe . All preparation, serving equipment, and surfaces that have been in contact with raw meats and other raw foods will be cleaned and sanitized to avoid cross contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to wear personal protective equipment when providing care and failed to remove personal protective equipment prior to exiting the room for residents on Enhanced Barrier Precautions. The facility failed to ensure hand hygiene was performed between resident care to prevent the spread of infection. This applies to 5 of 18 residents (R4, R7, R18, R22 and R59) reviewed for infection control in the sample of 18. The findings include:1. On 11/17/25 at 12:06 PM, V12, Certified Nursing Assistant (CNA) entered R4's room, applied gloves and assisted her to use the restroom. V12 then removed her gloves and transported R4 to the dining room. Once in the dining room, a resident stated that he had R18's meal tray. V12 picked up R18's meal tray and placed it on another table where R18 sits for meals. V12 then exited the dining room and went into R59's room and put gloves on and started providing care to R59. V12 did not perform hand hygiene before or after any of the above. On 11/18/25 at 1:13 PM, V12 said that hand hygiene should be done before and after patient care and before and after glove use. The facility's Hand Hygiene Policy shows, Purpose: Provide guidelines on proper and appropriate hand washing and hygiene techniques that will aid in the prevention of transmission of infections Staff will perform hand hygiene .Before applying gloves and after removing gloves after providing direct patient care .After contact with inanimate objects (e.g., medical equipment) in the immediate vicinity of the resident . 2. On 11/17/25 at 11:09 AM, R22 had a sign on her door showing that she was on Enhanced Barrier Precautions. V22 applied personal protective equipment (PPE) before entering the room. V22 (CNA) provided care to R22 and then exited the room with her PPE on and went to the linen cart in the hallway to retrieve a blanket and then re-entered the room. On 11/18/25 at 1:13 PM, V12 (CNA) said that PPE should be taken off before exiting a room and should not be worn in the hallways. On 11/19/25 at 12:13 PM, V2 (Director of Nursing) said that staff should not exit the room with PPE on after they provided care to a resident on Enhanced Barrier Precautions. The facility's How to Safely Remove Personal Protective Equipment (PPE) Procedure shows, Remove all PPE before exiting the patient room . 3. On 11/17/25 at 10:10 AM, R7's door had a sign that said she was on enhanced barrier precautions (EBP). V3 and V4 both Certified Nursing Assistants (CNAs) were providing perineal care and getting R7 up for the day. They were only wearing gloves and not a gown. R7 had 2 open weeping wounds on her left gluteal fold and mid-thigh. She also had a wound on her right ankle. R7 stated, they are chronic wounds that she has had for a long time. V4 CNA stated, they don't always wear gowns just depends on what they are doing with the resident. On 11/18/25 at 1:30 PM, V5 Infection Control Nurse stated, staff should be wearing full PPE (personal protective equipment) when caring for residents on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's current order summary report printed on 11/18/25 shows, Precautions: Enhanced Barrier Precautions. The facility's enhanced barrier precautions dated 4/28/25 show, Purpose: Reduce the transmission of novel or targeted multi-drug-resistant organisms (MDRO). Procedure: 1. Enhanced Barrier Precautions (EBP) require the use of gown and glove during high contact resident care activities. High-contact resident care activities include: .transferring, providing hygiene (e.g. brushing teeth, combing hair, shaving), changing linens, changing briefs or assisting with toileting. Note: Gowns and gloves are the minimum level of PPE. Additional PPE may be required depending on the situation/resident (e.g., face shield may be used when splashes and sprays are likely to occur). 3. Enhanced Barrier Precautions apply to residents with a wound (chronic wounds, not shorter-lasting wounds, such as skin breaks or tears covered with an adhesive bandage e.g., Band-Aid) or similar dressing or indwelling medical device (e.g, central line, urinary catheter, feeding tube, tracheostomy/ventilator), even if the resident not known to be infected or colonized with a MDRO.