STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145239	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Peoria Heights	5533 North Galena Road Peoria Heights, IL 61614

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents' call lights were answered promptly and residents received timely incontinence care for two of four residents (R2 and R15) reviewed for dignity in the sample of 16. These failures resulted in R2 and R15 lying in urine and feces for an extended period of time, causing R2 to feel pain, embarrassed, ashamed, disgusted, and R15 experiencing pain and burning to R15's buttocks causing R15 to feel like H*ll and disgusted. Findings include:Findings include:The facility's Daily Census Report, dated 1/26/26, documents 53 residents reside in the facility.The facility's Dignity Policy, dated 4/23/18, documents Guidelines: The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility shall consider the residents' lifestyle and personal choices identified through the assessment process to obtain a picture of his or her individual needs and preferences. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth.The Ombudsman Resident's Rights Booklet, dated 11/18, documents Your rights to dignity and respect: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your rights to safety: Your facility must provide services to keep your physical and mental health at their highest practical levels.The facility's Incontinence Care Policy, dated 4/20/21, documents Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode.The facility's Call Light Policy, dated 2/2/18, documents Purpose: To respond to resident's requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in a timely manner. 2. All staff should assist in answering call lights. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered. Procedure: 1. Answer light (signal) promptly.The facility's Certified Nursing Assistant Job Description, dated 5/2/17, documents Certified Nursing Assistant: Summary- The CNA (Certified Nursing Assistant) is responsible for providing resident care and support in all activities of daily living and ensures the health, welfare, and safety of all residents. Essential Duties and Responsibilities: Provide for resident comfort by utilizing resources and materials; answering call lights and requests; reporting observation of the residents to the nursing supervisor.On 1/27/26 at 12:02 PM V17/Ombudsman stated every month during resident council the residents complain of call light waiting times. On 2/10/26 at 12:58 PM R16 stated that the last four resident council meetings residents have complained about their call lights not getting answered timely and having to sit in urine and feces for long periods of time. R16 also stated The resident's state that it's more on second and third shift that staffing is short. The staff will tell them they (staff) don't (continued on next page)

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

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	have enough staff to get to everyone timely. 1.R2's admission Record documents R2 is a [AGE] year-old female who was admitted to the facility on [DATE] with the following but not limited to diagnoses: Periprosthetic Fracture around Internal Prosthetic Left Knee Joint, Type Two Diabetes Mellitus, Unspecified Fracture of Lower End of Left Femur, Muscle Wasting and Atrophy, Restless Leg Syndrome, Fibromyalgia, Age-Related Osteoporosis without current Pathological Fracture, and Other Abnormalities.R2's MDS (Minimum Data Set) assessment dated [DATE] documents R2 is cognitively intact, is dependent on staff for ADLs (Activities of Daily Living) including toileting hygiene and is frequently incontinent of bowel and bladder.R2's current Care Plan documents, R2 requires dependent assistance for toileting hygiene and requires a mechanical lift with two staff to transfer R2 from the chair to the bed.On 1/27/26 at 1:29 PM R2 stated, I laid in poop and pee for hours before any staff would answer my call lights at the facility. I was able to use the bed pan. If staff didn't answer my call light timely, I would have an accident and lay in my own poop and pee. Sometimes I would wait more than two and a half hours before someone could clean me up. I was so embarrassed and ashamed to lay in my own poop and pee that long. If the staff did get me on the bed pan in time, the staff wouldn't come back and take me off the bed pan, leaving me sitting on the bed pan for sometimes two hours. It was very painful. I came to the facility after I had surgery and was completely helpless and relied on staff to provide me with care. They would not get me up out of bed because it took two of them and they would say they didn't have enough staff to get me up and then put me back to bed later. It caused me complete embarrassment and humiliation along with disgust. In my opinion that facility should be shut down. R2 reported staff would always say they did not have enough staff to change everyone timely on their shift.On 1/27/26 at 12:47 PM V35/LPN (Licensed Practical Nurse) stated she was working at the facility when R2 was a resident. R2 was able to make her needs very known. R2 required dependent assistance with changing her and was incontinent at times. V35 stated, The Administration felt like the amount of CNA's we had were adequate on second and third shift, but a lot of the residents are two assist or cares in pairs, so the CNAs never had enough time to round on every resident in eight hours. There were times (R2) had to wait a while before a staff could get to her to clean (R2) up.On 1/29/26 at 11:43 AM V52/LPN stated, I can say it's true that they have to wait longer periods of time on nights due to the staffing. It's a constant complaint about waiting long periods of time to be changed or just not getting their call light answered timely in general. (R2) was one of them who had to wait.On 2/3/26 at 10:43 AM V6/Occupational Therapist stated, I only worked with (R2) once, but she was very cooperative. (R2) did complain to me about having to sit on the bed pain for an extended amount of time, I believe over two and half hours.2.R15's admission Record documents R15 is a [AGE] year-old-male who was admitted to the facility on [DATE] with the following but not limited to diagnoses: Nontraumatic Intracerebral Hemorrhage, Acute Kidney Failure, Muscle Wasting and Atrophy, Hyperkalemia, Acute Cystitis without Hematuria, Hypertension, Pain (unspecified), Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, and other Intervertebral Disc Degeneration (Lumbar Region).R15's MDS dated [DATE] documents R15 is dependent on staff for ADLs including toileting hygiene, toileting transfers, is occasionally incontinent of bladder, and frequently incontinent of bowel.R15's current Care Plan documents, R15 has an ADL self-care performance deficit related to having a stroke, requiring substantial to maximum assistance with toileting hygiene and transfers.On 2/10/26 from 1:02 PM to 1:36 PM, R15's call light remained on during this time.On 2/10/26 at 1:37 PM R15 was lying in his room with the covers pulled down and had on a disposable brief. R15 stated, A CNA (Unknown) came in around 25 minutes ago and asked what I needed. I told them I was wet and had pooped and I needed to be changed. The CNA told me she was going to go get washcloths and (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	be right back. She never returned. This happens all the time and makes me feel disgusted and like h*ll. My call light has been on for at least thirty to forty minutes, and I have had to sit in my own poop. Last Sunday I pooped and peed in my bed, turned on my call light around 3:30 PM and sat there until 6:30 PM until a staff member came to my room. My butt was burning and sore. Staff always say, We don't have enough staff, so you will have to wait until we get to you.On 2/10/26 at 1:38 PM V49/CNA was observed sitting in a chair in the hallway documenting on the computer. V49 stated, I just got back to this hall a little bit ago. I didn't realize (R15's) call light had been going off that long. V49 stated she was not the staff member who told R15 she would be right back with wash cloths to clean him up but stated, Staff be dipping out like that on resident's all the time. Answer the call light, tell the resident they will be right back, then not go back in.On 2/10/26 at 1:42 PM V50/CNA stated, I was the assigned CNA on (R15's) hallway. I know that (R15's) call light has been on for a while, but I was the only CNA on this side at the time. Another CNA and I were the only two passing hall trays and having to answer all the call lights. Then by time we are done with that, the residents come back from the dining room, so then they want to be laid down. It's hard to get to everyone timely.On 2/13/26 at 12:36 PM V2/Corporate Interim Director of Nursing stated the staff should answer residents' call lights as soon as they can and that thirty to forty-five minutes is too long for a call light to not be answered.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to refund money owed to a resident's representative timely after the resident left the facility for one of three residents (R3) reviewed for resident funds in the sample of 16. Findings include:The Abuse policy dated 10/24/22 documents This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent.R3's computerized Medical Record documents that R3 is a 96 -year-old that admitted to the facility on [DATE] with diagnoses which included Essential (Primary) Hypertension, Age Related Cognitive Decline, Type 2 Diabetes Mellitus, and Dementia. R10 passed away on 10/10/25. R3's admission Contract dated 3/31/21 and signed by R3 documents Should a resident pass away with funds remaining in his facility account or cash within the facility, facility will only release the funds upon receipt of letters of office from the executor or administrator of the Resident's estate or upon a validly executed small estate's affidavit. Any and all monies remaining after Resident discharges from the facility will be returned to the resident after facility has received all payments from third party payor sources.R3's Nursing Note dated 10/10/25 at 6:55 PM documents Hospice came and called all parties. Coroner picked up body at 5:43 PM.An email written by V15/Human Resource (HR)/Business Office Manager (BOM) to V16/Corporate Bookkeeper dated 10/28/25 at 1:38 PM, documents (V8/R3's Family Member) called. (V8) was concerned that she will not receive refund due to showing a past due balance. That month was paid. V16/Corporate Bookkeeper replied to V15 on 10/28/25 at 2:58 PM, I have her (V8) listed for refund in the amount of 1940.00 (dollars). V15 replied to V16 on 10/28/25 at 3:11 PM, Perfect, thank you! I also have a check that I received in. I was going to mail out tomorrow or Thursday for her (V8). R3's [NAME] Statement dated 1/1/26 documents a balance of 10,465 dollars.An email written by V16/Corporate Bookkeeper to V15/HR/BOM dated 1/22/26 at 11:11 AM, documents Working on refunds and follow ups now. As of now we have a total refund amount of $10465 with no other anticipated charges.On 1/27/26 at 10:45 AM V1/Administrator in Training stated she had asked V15/Business Office Manager yesterday if V8/R3's Representative had gotten a refund from R3 discharging. V1 was told that it was submitted to Corporate, so it was in the process. On 1/27/26 at 10:55 AM, V15/Human Resource/HR/Business Office Manager/BOM stated that notification was sent to V16/Corporate Bookkeeper when R3 passed away. V15 stated that V8/R3's Representative is owed a refund. V15 does not know how long it should take for the money to get refunded. On 1/27/26 at 1:00 PM, V15/HR/BOM stated that V16 told V15 the refund was not given because they had that R3 was owed 1,940 dollars and that is what was requested to be refunded. Then a payment was received to R3's account so the amount to be refunded needed to be adjusted. When the request was readjusted the facility fell behind on that request and had to get preapproval. If the amount was less than 5,000 dollars it would get processed quicker. V15 also stated Refunds are not processed as quick and not done timely. I do not have a policy on refunds. The Medicaid and Medicare refunds are processed sooner than Private pay refunds. I will take full responsibility that I did not stay on top of it. It should (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been done by at least December 2025.On 1/27/26 at 2:01 PM, V19/Sister Facility Administrator stated that in certain instances it takes 30 days other times it is 45 days to be issued a refund.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 showers were completed as scheduled and hygiene assistance was provided to dependent residents for six of six residents (R1, R2, R5, R6, R7, and R9) reviewed for ADL (Activities of Daily Living) assistance in the sample of 16. Findings include: The facility's Bathing-Shower and Tub Bath Policy, dated 10/2024, documents Purpose: To ensure resident's cleanliness to maintain proper hygiene and dignity. Guidelines: A shower, tub bath or bed/sponge bath will be offered according to resident's preference, no less than once per week or according to the resident's preferred frequency and as needed or requested. The facility's Nail Care Policy, dated 1/25/18, documents Guidelines: 1. Observe condition of resident nails during each time of bathing. Note cleanliness, length uneven edges, and hypertrophied nails. 4. After bathing, use orange sticks, and clean debris from around and under finger and toenails. 5. Trim toenails carefully in a straight fashion and fingernails in an oval fashion avoiding tissue after bathing or when needed. Be sure nails are soft before trimming. Additional soaking in warm soapy water may be necessary to soften nails. 1.R2's Care Plan documents R2 admitted to the facility on [DATE] and has an ADL (Activities of Daily Living) self-care performance deficit with a varying level of assisted needed related to diagnoses of fibromyalgia, osteoporosis, history of fracture, and restless leg syndrome related to Dementia, Weakness, Unsteady Balance, Demyelinating Disease of the CNS (Cranial Nervous System), Depression, PTSD (Post Traumatic Stress Disorder), Neuropathy, Fibromyalgia, and Pain. This same Plan of Care documents R2 requires dependent assistance with transferring and requires assistance by staff for shower/bathing. R2's MDS (Minimum Data Set) assessment dated [DATE] documents R2 is cognitively intact and requires dependent staff assistance for showering/bathing. R2's Medical Record does not document any showers given from 10/24/25 through 12/20/25. On 1/27/26 at 9:29 AM R2 stated, The staff did not wash my face, wash me up, or give me showers. I did not receive a shower the entire time I was at the facility. I would ask for one and they would say they didn't have time. On 1/29/26 at 12:04 PM V2/Corporate Interim Director of Nursing stated staff should be documenting showers in the electronic medical record. We (the facility) no longer use shower sheets. V2 verified there was no documentation for R2 receiving a shower while she was admitted at the facility. 2. R5's computerized Medical Record documents that R5 is a [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Heart Failure, Anoxic Brain Damage, Acute and Chronic Respiratory failure with Hypercapnia, and Chronic Obstructive Pulmonary Disease. R5's MDS assessment dated [DATE] Section GG (Functional Ability) documents R5 is dependent on staff for all ADLs, showering, toileting, bed mobility, and transfers. R5's Care Plan document that R5 has an ADL self-care performance deficit, is bedfast, and R5 is dependent on staff for showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Medical Record does not document when R5 received showers. R5's Nursing Note written by V35/Licensed Practical Nurse/LPN dated 12/19/25 at 8:30 PM, documents Family member of (R5) voiced concerns about (R5) not receiving a shower. Explained to family member that although (R5) has not been assigned a shower day in the system, hygiene maintenance has been performed in the form of bed baths. (R5) is currently on Isolation Precautions and may not be able to utilize the community shower room. DON (Director of Nursing) notified of the need to have (R5) added to the shower schedule in (the computer). On 1/28/26 at 12:04 PM, V27/R5's Family Member stated that she came to the facility several times a week to visit with R5. R5 needed to have a shower and staff refused to give R5 a shower. A nurse (unidentified) said that R5 could not go to the shower because he was in isolation. R5 went without a shower for at least two to three weeks. V27 also stated They (staff) said they were giving (R5) bed baths, but I knew it was not being done due to the way (R5) looked. On 2/10/26 at 12:04 PM, V3/MDS Coordinator verified that there was no documentation in R5's Medical Record that showed when R5 had gotten a shower. 3. R6's computerized Medical Record documents that R6 is a [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Diffuse Traumatic Brain Injury, Tracheostomy Status, Essential (Primary) Hypertension, and Acute Respiratory Failure. R6's MDS assessment dated [DATE] Section GG (Functional Ability) documents R6 is dependent on staff for all ADLs, showering, toileting, bed mobility, and transfers. R6's Care Plan documents that R6 has an ADL self-care performance deficit and R6 is dependent on staff for personal hygiene. R6's Medical Record does not document when R6 received showers. On 1/27/26 at 10:15 AM V9/R6's Family Member stated I am at the facility every day to be with (R6). They (staff) are supposed to give (R6) a shower two times a week and last month (R6) had one shower total, so I gave (R6) a sponge bath. (R6) got one shower last week for the first time in three to four weeks. On 2/10/26 at 12:04 PM, V3/MDS Coordinator verified that there was no documentation in R6's Medical Record that showed when R6 had gotten a shower. V3 also stated We do not do paper shower sheets. If showers are not documented in the computer, then they aren't done. 4. R1's current Care Plan, dated 1/20/26, documents R1 was admitted to the facility on [DATE] with multiple diagnoses including Lung Cancer, Brain Cancer, Failure to Thrive, Muscle Wasting and Atrophy, and Abnormalities of Gait and Mobility. This care plan documents I have an ADL (Activities of Daily Living) self-care performance deficit with a varying level of assistance needed related to Metastatic Lung cancer with Bone and Brain involvement, Cancer Pain, history of TBI (Traumatic Brain Injury). The resident is usually provided with substantial/maximum assist by staff for hygiene and bathing. On 1/26/26 at 1:16 PM, V11 (R1's family) stated (R1) has only had two showers since 1/4/26. They (facility staff) don't even wipe (R1) down daily. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/26 at 10:40 AM, R1 was in his room sitting in wheelchair. R1 was dressed but his feet were without socks and shoes. R1's toenails appeared long and thick. R1's shirt contained a lot of white flecks of skin like dander and debris. R1's fingernails appeared orange around the edges. R1's current electronic medical record does not document that R1 has received a shower or bath since admission. 5. R7's current Care Plan, dated 3/28/25, documents I require assistance to: -bathe/shower, dress upper body, dress lower body, dress, comb hair, shave, apply makeup, brush teeth/denture care related to Dementia. Assist resident to shower, sink, tub. This same care plan also documents The resident is usually able to perform ADLs with assist of one staff member with verbal cues and set up related to confusion/decline in cognition, impaired balance, limited mobility. Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. On 1/27/26 at 10:43 AM, R7 was sitting in a chair in room. R7's fingernails were caked with orange and yellow debris under the nails and on the sides of R7's nail bed. R7's hair was slicked back in a hair restraint with some hair on top of her head sticking up with a stiff like appearance. On 1/29/26 at 1:15 PM, R7 was sitting in a chair in her room. R7's fingernails were long past her finger pads and contained orange crusty matter underneath all of her fingernails. On 1/29/26 at 1:17 PM, V49 (Certified Nursing Assistant, CNA) stated she was aware R7's nails needed cleaned and confirmed the orange crusty matter underneath all nails. V49 stated nails should be cleaned when they are dirty as needed and during showers. R7's current electronic medical record does not document that R7 has received a shower in December 2025 or January 2026. 6. R9's current Care Plan, dated 12/22/25, documents I have an ADL self-care deficit with a varying level of assistance needed related to hemiplegia. This care plan documents R9 is dependent on staff for all cares and hygiene. R9's current electronic medical record does not document that R9 has received a shower in December 2025 or January 2026. On 1/29/26 at 1:10 PM, V2 (Director of Nursing) stated they (the facility) do not have any documentation to show that R1, R2, R5, R6, R7, or R9 have had any showers completed in December or January (past 2 months). V2 stated We do not do shower sheets and CNAs should be documenting showers under tasks, but those residents do not have any showers documented.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities daily on the day and evening shifts designed to meet the resident's physical, mental, and psychosocial well-being of each resident. These failures have the potential to affect all 53 residents residing within the facility. Findings include:The facility's Daily Census Report, dated 1/26/26, documents 53 residents reside in the facility.The facility's Activities Program, dated 11/7/19, documents Purpose: To provide an ongoing program of activities designed to appeal to the residents' interests and to enhance his or her highest practical level of physical, mental, and psychosocial well-being. Guidelines: The Activity Director, trained staff, or volunteer will: 1. Identify and involve each resident in an ongoing program of activities that is designed to appeal to his or her interests and needs. 2. Enhance the resident's highest practical level of physical, mental, and psychosocial well-being by offering a program of activities that provides the following: a. A heightened sense of well-being. b. Promotion of feelings of self-esteem, pleasure, comfort, education, creativity, success, independence. g. Allow for socializing with visitors and participating in community events. i. Physically active programming. 3. A minimum of four-seven organized activities will be scheduled daily. 4. Provide programs for residents who will not, or cannot, effectively plan their own activity pursuits. 6. The program of activities will include a combination of large and small groups, one to one's, and self-directed activities. Activity Participation Records: The activity staff shall record resident's activity attendance and participation on a daily basis. The system used will record the activity attended, the resident's level of participation (active vs. passive) and whether the resident was invited to the activity but declined the invitation or had a conflict and was not available. 1. Upon the conclusion of each planned, scheduled activity or as time permits, the Activities Director and/or designee shall record the activity attended as well as the resident's overall level of participation (active vs. passive). The Activity Director and/or designee shall also note whether the resident was invited to the activity but declined the invitation or had a conflict. 3. Make use of attendance records as data for summary within resident activity assessments and/or progress notes.The facility's Facility Assessment Tool, dated 11/1/25, documents Provide person-centered/directed care: Psycho/social/spiritual support- Find out what resident's preferences and routings are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process. Support emotional and mental well-being; support helpful coping mechanisms; support resident having familiar belongings. Provide culturally competent care: Learn about resident preferences and practices with regard to culture and religion; stay open to requests and preferences and work to support those as appropriate; Provide or support access to religious preferences, use or encourage prayers as appropriate/desired by the resident; Provide opportunities for social activities/life enrichment (individual, small group, community). Support community integration if resident desires; Identify hazards and risks for residents; and offer and assist resident and family care.The facility's Activity Calendar, January 1st through January 31st, 2026, does not include any scheduled evening activities or scheduled weekend activities.On 1/26/26 from 9:15 AM to 3:00 PM residents were not observed in activities, and no announcements were made about activities.On 1/27/26 from 9:15 AM to 3:00 PM residents were not observed in activities, and no announcements were made about activities.On 1/27/26 at 12:02 PM V17/Ombudsman stated, During resident council today, the residents stated they were very bored. The facility has not been having activities going on, no calendar has been posted or passed out to the residents' rooms, and they have not been offering daily activities. Residents have told me they have to figure out their own activities to do.On 1/27/26 at 12:47 PM V35/LPN (Licensed Practical Nurse) stated the facility (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was not providing activities during the day or during the evening time. V23 stated, Residents who are alert would tell me they have to do their own things or smoke outside more frequently because they are so bored. The residents would complain they never got to have a movie night either.On 1/27/26 at 2:46 PM V20/LPN was preparing medications at the medication cart. V20/LPN stated she typically works day shift 6:00 AM to 6:00 PM. V20 verified no activities were offered today with the residents and residents were complaining again. On 1/28/26 at 10:15 AM, multiple residents were observed in the facility's activity room. R10, R11, R12, and R13 all stated the facility does not have activities every day. At this same time, R14 also confirmed there are no daily activities and stated They do not have a fulltime Activity Director. We have coloring pages and play bingo sometimes.On 1/28/26 at 10:24 AM a tour was conducted with V2/Interim DON (Director of Nursing) to see if a January 2026 activity calendar was posted around the facility or in resident rooms. No printed activity calendars were observed in any resident's rooms during this time or posted around the facility. In the activity room, a large bulletin board was observed with small cut out pieces labeled one through 31 with different activities listed on them. These small pieces of paper do not have a date or indicate what month they are for. V2/Interim DON and V25/Housekeeping Supervisor both verified those small pieces of paper labeled one through 31 with different activities listed on them stay there each month with the same activities listed and have not been changed out.On 1/28/26 at 11:38 AM V25/Housekeeping Supervisor stated she fills in at times to perform activities with the residents since the facility has no Activity Director or activity staff, but it is not often. V25 verified no activities were performed with the residents on 1/26/26 and 1/27/26. V25 stated, The last two days I had to help on the floor, so I was unable to ensure activities were being done with the residents. There are no planned activities after 4:00 PM or on the weekends for the residents.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review, the facility failed to ensure a residents fecal collection system (rectal tube) was assessed and monitored, replaced after removal and care planned to ensure optimal outcome for one of one resident (R9) reviewed for rectal tubes in the sample of 16. This failure resulted in R9 going 17 days without proper fecal management collection and contributing to R9 developing infection in a stage four sacral pressure ulcer, requiring hospitalization with a diagnosis of sepsis and stage four sacral ulcer with osteomyelitis.Findings include:The facility's Guidelines for Management of Fecal Incontinence with (flexible seal) policy, dated 2/2011, documents Objective: To effectively divert and contain liquid and semi-liquid stool away from the body. Outcomes: Keep skin clean and dry; free from contaminants that contribute to skin breakdown. Contain infectious body waste contained within a closed drainage system to minimize risk of spread of bacteria. Protect surgical wounds and pressure ulcers from contamination by stool. Keep environmental odor to a minimum. Increase patient comfort. Notify physician if any of the following occur: persistent rectal pain, rectal bleeding, abdominal distention. As with the use of any rectal device the following adverse events could occur, excessive leakage of stool around the device, loss of anal sphincter muscle tone could lead to temporary anal sphincter dysfunction, pressure necrosis of rectal or anal mucosa, infection, bowel obstruction, perforation of the bowel. Maintenance: observe the device frequently for obstructions from kinks, solid fecal particles or external pressure.R9's admission Observation assessment, dated 12/22/25, documents R9 originally admitted to the facility on [DATE] with a stage four pressure ulcer wound to his coccyx and is dependent on staff for all activities of daily living, mobility and care.R9's Care Plan, dated 12/16/25, documents R9 has diagnoses including but not limited to Tracheostomy status, Gastrostomy status, Critical illness Myopathy, Pressure ulcer of Sacral region, stage IV (four), Osteomyelitis of vertebra, Sacral and Sacrococcygeal region. This care plan documents I have a pressure ulcer coccyx related to immobility, history of CVA (cerebrovascular accident), bowel incontinence and as evidenced by braden (skin assessment) score. Administer treatments as ordered and monitor for effectiveness. Follow facility protocols for the prevention/treatment of skin breakdown. Obtain and monitor lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated. The resident requires a pressure relieving/reducing mattress on bed. This same care plan does not document a plan of care for R9's rectal tube.R9's Physician Order sheet dated 11/20/25-2/10/26 documents R9 has an order started on 11/20/25 to monitor placement and empty contents of rectal tube every shift for wound care.R9's Treatment Administration Record (TAR), dated 11/20/25-1/17/26, does not document any monitoring of R9's rectal tube placement, assessment or bowel contents.R9's nursing progress note, dated 1/1/26 at 10:23 PM, documents Resident rectal tube fell out. Called MD (V22, Facility Medical Director) and he said to monitor and call the surgeon. This nurse could not find surgeon's number. DON (V2, Director of Nursing) notified, care ongoing.R9's progress note, dated 1/10/26 at 10:03 AM and completed by V30 (Facility Nurse Practitioner), documents Wound MD (Medical Doctor, V54 wound physician) stated that if (R9) does not want the fecal tube in place that is okay to leave out. The wound will heal better with it in place. Asked (R9) what his wishes were and he shook his head no. Rectal tube was placed to prevent contamination of wound, this has come out on two occasions this admission. No replacement rectal tube at bedside. Previously attempted to re-order and product was out of stock. (V32, R9's family) would like one re-ordered. Will verify with (R9) and re-order as needed.R9's progress note, dated 1/12/26 at 4:14 PM and completed by V30, documents Rectal tube was placed to prevent contamination of wound, this has come out on two occasions this admission. No (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	replacement rectal tube at bedside. Previously attempted to re-order and product was out of stock. (V32) would like one re-ordered. Discussed with (R9) today that the rectal tube can help with wound healing so that it does not get contaminated. He did consent that this would be OK to re-insert. Will follow up with DON (V2) about ordering.R9's progress notes, dated 1/1/26- 1/17/26, do not document R9's gastric surgeon (unknown) was notified of the rectal tube removal or that the rectal tube was not ever replaced.On 1/28/26 at 12:40 PM, V32 (R9's Family) stated that three weeks into (R9's) stay at the facility, he was re-admitted to the hospital with a wound infection. V32 stated the facility never replaced R9's rectal tube after it came out for the second time. V32 stated (R9's) wound is to the bone and the size of a [NAME] and when staff clean R9's bowel contents up, the pad over his wound also becomes soiled. I have seen that stool-soaked wound pad sit for over four hours before a nurse changed the wound dressing.R9's Hospital Emergency Department-admission record, dated 1/17/26, documents R9 presented to the emergency room with fever, abdominal pain, diarrhea, nausea and vomiting and R9's appearance was ill-appearing and toxic-appearing. This record also documents R9 was admitted with a diagnosis of Sepsis with several contributing sources including a stage four decubitus ulcer with concerns for osteomyelitis.On 1/29/26 at 12:15 PM, V22 (Facility Medical Director) stated Stool getting into a wound would definitely cause contamination. When (R9's) rectal tube came out, I wanted him to follow up with the gastric surgeon due to the g-tube (gastrostomy tube) and worried about his bowel and possible placement issues with that. So, I did want the surgeon notified when it came out and I wasn't aware they didn't notify the surgeon.On 1/29/26 at 12:50 PM, V33 (emergency room Physician) confirmed seeing R9 in the emergency room on admission to the hospital (1/17/26) and confirmed that R9 has been admitted to the hospital twice with Sepsis and a Stage IV pressure ulcer with osteomyelitis. V33 stated (R9) is a very sick person and it's unfortunate. The Sepsis could come from multiple sites. In (R9's) case he had a stage IV, very deep, decubitus ulcer. Certainly, if stool were to enter into that wound bed it can lead to infection.On 1/29/26 at 1:20 PM, V30 (Nurse Practitioner) confirmed R9's sacral pressure ulcer was to the bone and R9 had a rectal tube to keep his wound clean which was removed on 1/1/26. V30 stated The rectal tube was never re-inserted for R9 due to it not being available. V30 also stated nurses should be assessing residents' skin daily to monitor for signs of pressure or impaired skin integrity.On 2/2/26 at 10:00 AM, V2 (Director of Nursing) stated she was not aware that R9 was not receiving rectal tube monitoring. V2 confirmed when the rectal tube was unavailable from their supplier, the facility did not reach out to the hospital to purchase a replacement tube.On 2/10/26 at 1:00 PM, V4 (ADON/ Wound Nurse) confirmed that R9's rectal tube was in place to help keep his sacral pressure ulcer clean. V4 also confirmed this tube was not on his care plan and R9's electronic medical record does not contain documentation to show that it was monitored every day. V4 stated The order for (R9's) rectal tube was not put in correctly and so there is no record that the site was monitored, including the amount of stool or nursing assessment to ensure placement was secure and without concern. (R9) did not have a care plan in place for the rectal tube and should have.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety 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 interview and record review, the facility failed to identify, assess, and treat a facility-acquired pressure ulcer, prevent a pressure ulcer from worsening, administer wound treatments as ordered, develop and implement pressure relieving interventions and a pressure ulcer care plan for two of three residents (R4, R9) reviewed for pressure ulcers in the sample of 16. This failure resulted in R4 developing a facility acquired pressure ulcer and R4 and R9's wounds worsening without adequate treatment and being transferred to the hospital with lethargy, high fever and requiring extensive hospitalization for diagnoses of sepsis and a stage four decubitus pressure ulcer with osteomyelitis.These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 11/7/25 when R4 was identified at high risk of developing a pressure ulcer. V1 (Administrator in Training) and V2 (acting Director of Nursing) were notified of the Immediate Jeopardy on 2/2/26 at 10:00 AM. While the immediacy was removed on 2/10/26, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.Findings include:Findings include: The Pressure Ulcer Prevention policy dated 1/15/18 documents Purpose: To prevent and treat pressure sores/pressure injury. Guidelines: 1. Maintain clean/dry skin during daily hygiene measures. 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. 5. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. 6. Employ active and passive range of motion exercises to improve circulation as indicated (in accordance with physician order and plan of care). 12. Encourage resident to maintain proper nutrition and hydration, providing supplements as ordered and necessary assistance at mealtime as needed. 14. Moisture barrier may be applied by CNA (Certified Nursing Assistant) as needed to intact skin and may be kept at bedside. The Skin Condition Assessment and Monitoring -Pressure and Non-Pressure policy dated 6/8/18 documents Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Guidelines: Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record. A skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and as necessary. Residents identified will have a weekly assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident's chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. Caregivers are responsible for promptly notifying the charge nurse of skin breakdown. At the earliest sign of the injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes. Wound Assessment/Measurement: 6. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches, and goals for care. 7. Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses note. 1. R4's computerized Medical Record documents that R4 is a [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Failure with Hypoxia, Tracheostomy (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Status, Gastrostomy Status, and Encephalopathy. R4's Skin Condition Report dated 10/28/25 documents that R4 had no wounds. R4's MDS (Minimum Data Set) assessment dated [DATE] Section C (Cognitive Patterns) documents that R4 is severely cognitively impaired. Section GG (Functional Ability) documents R4 is dependent on staff for all activities of daily living/ADLs, toileting, bed mobility, and transfers. R4's Risk assessment dated [DATE] documents a Braden Risk Level of 9 (nine) Very High Risk. R4's current Care Plan does not have a care plan that R4 is at risk for pressure ulcers and does not have any interventions to prevent pressure ulcers. R4's Skin/Wound Note written by V4/Wound Nurse dated 12/12/25 at 2:08 PM, documents Notified by CNA (unidentified) (R4) had a wound on her coccyx. Evaluated. Open area to coccyx noted with moderate serous drainage. Appears to have large amount of scarring to the area. Fax sent to MD (Medical Doctor). Placed tx (treatment) order. R4's Progress Note written by V30/Nurse Practitioner/NP dated 12/24/25 documents (R4) is bedbound, in a vegetative state, nonverbal, and fully dependent for all ADLs. Interventions: Positioning and Skin Care: Dependent for all repositioning; staff to provide frequent turning and repositioning. Regular skin assessments; care of coccyx open wound. R4's Progress Note written by V30/NP dated 12/30/25 documents that R4's has a stage 3 (three) pressure ulcer to the sacral region. The wound measures 7 cm (centimeters) by 6.5 cm by 0.20 cm. Care Plan is for frequent turning/repositioning to off-load pressure from sacral area and dressing changes. R4's Treatment Administration Record for 12/1 - 12/31/25 documents to apply (medicated dressing) and gauze to R4's coccyx two times a day at 8:00 AM and 8:00 PM starting 12/12/25 at 8:00 PM. The treatment was not started until 12/13/25 at 8:00 PM. The treatments were not documented as being done on 12/17 at 8:00 AM, 12/18 at 8:00 PM, and 12/20 at 8:00 AM. On 12/20/25 the order was changed to apply (medicated dressing) and gauze to R4's coccyx every shift day and night starting 12/20/25 at 6:00 PM. The treatments were not documented as being done on 12/23, 12/26, 12/28 on days and 12/29/25 on nights. R4's Skin/Wound Note written by V4/Wound Nurse dated 1/9/26 at 3:15 PM, documents Left message for (POA/Power of Attorney) to obtain consent for wound MD (Medical Doctor) evaluation of wound to coccyx as it continues to decline and should be followed by Wound MD. R4's Follow UP Note written by V30/NP dated 1/15/26 at 6:55 PM, documents New tunneling of wound. R4's Nursing Note dated 1/18/26 at 10:21 PM, documents "Wound bed is draining copious amounts of dark yellow drainage almost constantly. R4's Progress Note written by V30/NP dated 1/19/26 documents that R4's pressure ulcer is a stage 4 (four) measuring 8 cm by 10 cm with deep tunneling, purulent, odorous drainage, with concerns for infection. R4's Nursing Note dated 1/21/26 at 7:53 PM, documents that R4 was slightly clammy with an increase (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in respirations and shortness of breath. R4's coccyx wound seems to have worsened. V22/Primary Care Physician was notified about concerns. V22 gave an order to send R4 to the hospital to be evaluated to rule out Sepsis. R4's Hospital Report dated 1/21/26 documents that Infectious Disease consulted and requested (V34/Hospital Doctor) for evaluation and antibiotic recommendation. R4 was admitted to the hospital by V34 on 1/21/26 with admitting diagnosis of Sepsis. Call placed to (the facility) and no one answered the phone today, 1/22/26 after multiple attempts. So unclear how long (R4) was ill at facility. ER (Emergency Room) notes indicate (R4) arrived with reports of fevers there 104-106 (degrees) unknown measurement or how long; accompanied by lethargy. R4's Nursing Note dated 1/22/26 at 1:23 AM, documents that the hospital reported there were signs pointing to Sepsis. R4 was started on Zosyn and Vancomycin. R4's Hospital Records dated 1/22/26 at 2:49 PM, documents that R4 presented to the ER/emergency room from the facility with complaints of fever and lethargy. Radiology Report documents Stage IV (four) sacral ulcer with ill-defined lower sacral and coccygeal posterior cortices which suggests osteomyelitis (this may also have a large component of volume averaging artifact). R4's Hospital Report dated 1/23/26 at 12:21 AM, documents (R4) has sepsis which could be from the pneumonia and/or wound infection of her chronic pressure ulcer, or both. R4's Hospital Clinical Notes dated 1/25/26 at 1:25 PM, documents that bedside surgical debridement was done. Necrotic skin bridges were sharply excised, and the wound bed was mechanically debrided. There was an area of darkened tissue over R4's sacrum that was unable to be debrided at the bedside. R4's Treatment Administration Record for 1/1 - 1/31/26 documents to apply (medicated dressing) and gauze to R4's coccyx every shift day and night. The treatments were not documented as being done on 1/2 and 1/5/26 on days, 1/8/26 on days or nights, and 1/12, 1/17, and 1/21/26 on days. On 1/21/26 at 4:00 PM, the order was changed to apply (medicated dressing) and gauze to R4's coccyx four times a day and as needed at 4:00 AM, 10:00 AM, 4:00 PM, and 10:00 PM. The dressing was done on 1/21/26 at 4:00 PM then R4 went to the hospital. On 1/27/26 at 12:47 PM V35/Licensed Practical Nurse stated that wound care could not be completed most of the time on night shift. The medication pass alone was too aggressive and then the charting had to be completed. Wound care would be the last thing we (staff) would do if we could even get to it. V35 also stated If I was working and the treatment was left blank it would mean I didn't do it due to not having enough time. On 1/28/26 at 11:00 AM, V4/Wound Nurse stated that she started doing the wounds around 12/1/25 taking over for V23/Prior Wound Nurse. V23 did not have any wound logs or wound measurements documented. V4 stated the first time she was told about R4's wound was on 12/12/25 and V4 would classify it as a Stage 3. The dressings were to be done twice a day then was changed to four times a day due to the amount of drainage. V4 stated The wound was getting worse. I thought it needed debrided. I brought it up to (V30/NP) and had to order the supplies. (R4) was sent out before we got the wound debrided. V4 also stated I check the Care Plan weekly and there was not a Care Plan for (R4's) wound as of last week. I have not put anything in yet. It is my job to do it and when it is identified it should be put in a care plan. V4 stated If the treatment is not signed out in the treatment log it did not get done. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/29/26 at 1:04 PM, V30/Facility Nurse Practitioner stated that the first time she saw R4's pressure ulcer was on 12/24/25. R4 was completely dependent on staff for her care. R4's wound continued to get worse and when R4 was sent to the hospital (1/21/26) the wound was a Stage 4 and was infected. V30 also stated that the dressings need to be changed as ordered or it absolutely would cause a problem causing the wound to worsen. 2. R9's admission Observation assessment, dated 12/22/25, documents R9 originally admitted to the facility on [DATE] with a stage four pressure ulcer wound to his coccyx and is dependent on staff for all activities of daily living, mobility and care. R9's Care Plan, dated 12/16/25, documents R9 has diagnoses including but not limited to Tracheostomy status, Gastrostomy status, Critical illness Myopathy, Pressure ulcer of Sacral region, stage IV (four), Osteomyelitis of vertebra, Sacral and Sacrococcygeal region. This care plan documents I have a pressure ulcer coccyx related to immobility, history of CVA (cerebrovascular accident), bowel incontinence and as evidenced by Braden (skin assessment) score. Administer treatments as ordered and monitor for effectiveness. Follow facility protocols for the prevention/treatment of skin breakdown. Obtain and monitor lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated. The resident requires a pressure reliving/reducing mattress on bed. R9's Physician Order sheet dated, 11/20/25-2/10/26 documents R9 has an order started on 11/20/25 to monitor placement and empty contents of rectal tube every shift for wound care and a wound treatment order to cleanse coccyx wound with (wound cleaner) and gauze. Apply skin prep to peri wound skin, foam to the wound bed and drape with wound vacuum every Monday, Wednesday and Friday. This order sheet also documents an order started on 12/23/25 to cleanse stage IV (four) coccyx wound with wound spray, pat dry and apply (wound cleanser) wet to dry dressing and cover with padded covering two times daily and as needed (PRN) for wound care. R9's Treatment Administration Record (TAR) dated 11/20/25-11/30/25 documents two of R9's scheduled wound treatments were not administered, and zero PRN treatments were completed. R9's TAR dated 12/1/25-12/9/25 documents two of R9's scheduled wound treatments were not administered, and zero PRN treatments were completed. R9's Hospital Summary, dated 12/22/25, documents R9 was evaluated in the emergency room with altered mental status and concern for infection and admitted to the hospital on [DATE] for Sepsis with suspected sources including a chronic stage IV sacral ulcer with imaging evidence of underlying abscess and sacrococcygeal osteomyelitis. This summary documents R9's deep wound cultures grew multiple bacteria including Enterococcus and Citrobacter freundii which R9 was treated for at the hospital before discharging back to the facility on [DATE]. On 1/28/26 at 12:40 PM, V32 (R9's Family) stated that three weeks into (R9's) stay at the facility, he was re-admitted to the hospital with a wound infection. V32 stated (R9's) wound is to the bone and the size of a [NAME] and when staff clean R9's bowel contents up, the pad over his wound also becomes soiled. I have seen that stool-soaked wound pad sit for over four hours before a nurse changed the wound dressing. R9's TAR dated 12/23/25-12/31/25, documents R9's physician ordered coccyx wound treatment was to be completed two times daily and as needed. This record documents five scheduled treatments were not completed and zero as needed treatments were administered. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R9's TAR dated 1/1/26-1/17/26, documents R9's physician ordered coccyx wound treatment was to be completed two times daily and as needed. This record documents seven scheduled treatments were not completed and zero as needed treatments were administered. This same administration record documents R9 was ordered to have Sodium Hypochlorite external solution 0.125% applied to the coccyx wound topically every 12 hours related to pressure ulcer treatment. This same record documents, ten scheduled sodium hypochlorite applications were not completed. R9's TAR's dated 11/20/25-1/17/26, do not document any site monitoring or assessments were ever completed for R9's rectal tube. R9's electronic medical record does not document R9 was provided daily nursing skin checks throughout R9's stay in the facility. R9's nursing progress note, dated 1/1/26 at 10:23 PM, documents Resident rectal tube fell out. Called MD (V22, Facility Medical Director) and he said to monitor and call the surgeon. This nurse could not find surgeon's number. DON (V2, Director of Nursing) notified, care ongoing. R9's progress note, dated 1/10/26 at 10:03 AM and completed by V30 (Facility Nurse Practitioner), documents Wound MD (Medical Doctor, V54 wound physician) stated that if (R9) does not want the fecal tube in place that is okay to leave out. The wound will heal better with it in place. Asked (R9) what his wishes were and he shook his head no. Rectal tube was placed to prevent contamination of wound, this has come out on two occasions this admission. No replacement rectal tube at bedside. Previously attempted to re-order and product was out of stock. (V32, R9's family) would like one re-ordered. Will verify with (R9) and re-order as needed. R9's progress note, dated 1/12/26 at 4:14 PM and completed by V30, documents Rectal tube was placed to prevent contamination of wound, this has come out on two occasions this admission. No replacement rectal tube at bedside. Previously attempted to re-order and product was out of stock. (V32) would like one re-ordered. Discussed with (R9) today that the rectal tube can help with wound healing so that it does not get contaminated. He did consent that this would be OK to re-insert. Will follow up with DON (V2) about ordering. R9's progress notes, dated 1/1/26- 1/17/26, do not document R9's gastric surgeon (unknown) was notified of the rectal tube removal and does not document that the rectal tube was ever replaced. R9's nursing progress note, dated 1/17/26 at 9:54 AM, documents V22 (Facility Medical Director) was notified of R9's gastrostomy tube (g-tube) leaking and a new order was received for CBC (Complete Blood Count), BMP (Basic Metabolic Panel), and KUB (Kidney Ureter Bladder imaging). R9's electronic medical record does not document any laboratory results throughout R9's entire admission [DATE]-[DATE]. R9's nursing progress note, dated 1/17/26 at 8:00 PM, documents (V22) ordered a KUB due to leaking g-tube. KUB results came back with no clear results due to faulty imaging. This same note documents V32 (R9's family) wanted R9 to be sent to the hospital due to no clear results from KUB imaging. (R9) sent to (local Emergency Room) per request of (V32). (V22) aware. R9's Hospital Emergency Department-admission record, dated 1/17/26, documents R9 presented to the emergency room with fever, abdominal pain, diarrhea, nausea and vomiting and R9's appearance was (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ill-appearing and toxic-appearing. This record also documents R9 was admitted with a diagnosis of Sepsis with several contributing sources including a stage four decubitus ulcer. On 1/28/26 at 11:08 PM, V4 (Assistant Director of Nursing (ADON)/ Wound Nurse) confirmed R4 and R9 do not have any documentation of daily skin monitoring. V4 stated nurses should be completing skin assessments on all residents especially when they have a high risk of skin breakdown, to identify concerns. On 1/30/26 at 1:22 PM, V4 stated R9 does not have any laboratory results in his medical record because none were completed at the facility. On 1/29/26 at 12:15 PM, V22 (Facility Medical Director) confirmed that wound treatments should be completed according to the physician orders, and the physician should be notified if there are issues completing wound treatments. V22 stated I had no idea wound treatments weren't being completed. Stool getting into a wound would definitely cause contamination. When (R9's) rectal tube came out, I wanted him to follow up with the gastric surgeon due to the g-tube (gastrostomy tube) and worried about his bowel and possible placement issues with that. So, I did want the surgeon notified when it came out and I wasn't aware they didn't notify the surgeon. On 1/29/26 at 12:50 PM, V33 (emergency room Physician) confirmed seeing R9 in the emergency room on admission to the hospital (1/17/26) and confirmed that R9 has been admitted to the hospital twice with Sepsis and a Stage IV pressure ulcer with osteomyelitis. V33 stated (R9) is a very sick person and it's unfortunate. The Sepsis could come from multiple sites. In (R9's) case he had a stage IV, very deep, decubitus ulcer. Certainly, if stool were to enter into that wound bed it can lead to infection. Even just improper care of a wound or not completing treatments, without stool involvement, can cause it to become infected. On 1/27/26 at 12:47 PM V35 (Licensed Practical Nurse) stated wound care could not be completed most of the time on third shift. V35 stated The medication pass alone was too aggressive and then the charting had to be completed. Wound care would be the last thing we would do if we could even get to it. If I was working and the treatment was left blank it would mean I didn't do it due to not having enough time. On 1/29/26 at 1:20 PM, V30 (Nurse Practitioner) confirmed R9's sacral pressure ulcer was to the bone and R9 had a rectal tube to keep his wound clean which was removed on 1/1/26. V30 stated The rectal tube was never re-inserted for R9 due to it not being available. V30 also stated nurses should be assessing residents' skin daily to monitor for signs of pressure or impaired skin integrity. On 2/2/26 at 10:00 AM, V2 (Director of Nursing) stated she was not aware that R9 was not receiving wound treatments, nursing skin assessments, physician ordered labs and rectal tube monitoring. V2 confirmed when the rectal tube was unavailable from their supplier, the facility did not reach out to the hospital to purchase a replacement tube. On 2/10/26 at 1:00 PM, V4 (ADON/ Wound Nurse) confirmed that R9's rectal tube was in place to help keep his sacral pressure ulcer clean. V4 also confirmed this tube was not on his care plan and R9's electronic medical record does not contain documentation to show that it was monitored every day. V4 stated The order for (R9's) rectal tube was not put in correctly and so there is no record that the site was monitored, including the amount of stool or nursing assessment to ensure placement was secure. He did not have a care plan in place for the rectal tube and should have. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/10/26 the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all Licensed Nurses on 2/2/26 on Physician Orders- Entering and Processing, and Documentation in the Health Record. The Physician Orders- Entering and Processing policy was included. 2. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all Licensed Nurses starting on 2/2/26 on Pressure Injury and Skin Condition Assessment. The Electronic Health Record policy was included. 3. A Facility Audit was started on 2/9/26 to identify all residents with Pressure Ulcers. This included the wound assessment being completed, the physician contacted, the wound nurse contacted, a reassessment of the wound in 24 hours, and consents to see the Wound Physician. There were 56 residents assessed. 4. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In Serviced staff starting on 2/2/26 on Pressure Injury and Skin Condition Assessment. The Pressure Injury and Skin Condition Assessment policy was included. The facility developed a process in which the direct care nurse is required to review the Treatment Administration Record prior to providing wound care. 5. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In Serviced staff starting on 2/2/26 on Pressure Ulcer Prevention and Med Error, Adverse Drug Reaction, Physician Orders- Entering and Processing, Documentation- Heath Record, and Comprehensive Care Plan, Baseline Care Plan. The Pressure Ulcer Prevention policy, Medication Administration General Guidelines, Physician Orders- Entering and Processing, and Comprehensive Care Plan were included. The facility implemented a process to ensure staff are trained to develop and provide interventions to prevent pressure areas and prevent pressure ulcers from worsening. These interventions include 1. Educate staff to review the Care Plan before care. 2. Nurses were educated on the facility Skin Policy. 3. Nurses were educated on Weekly Skin Assessments. 4. Nurses were educated on following physician orders. 5. Staff were educated on residents that have pressure ulcers and are dependent on staff for repositioning. 6. Clinical Staff and Dietary Staff were educated to follow the Physician Order and Meal Ticket to ensure the resident receives the correct diet and supplements. 7. Nurses were educated on following Physician Orders and reviewing the Medication Administration Record and Treatment Administration Record prior to conducting a medication pass and performing wound care. 8. Nurses were educated on conducting skin assessments when a resident returns from the hospital. 9. Nurses were educated to open risk management for skin breakdown and to notify the Wound Nurse and Director of Nursing. 6. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all staff starting on 2/2/26 on Pressure Injury and Skin Condition Assessment, and Skin Condition Assessment and Monitoring Pressure and Non-Pressure. The Pressure Injury and Skin Condition Assessment policy was included. 7. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all Nurses and Certified Nursing Assistants starting on 2/2/26 on Pressure Ulcer Prevention. The Pressure Ulcer Prevention policy was included. 8. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all staff starting on 2/2/26 on Change of Condition and Physician-Family Notification. The Physician- (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Family Notification- Change in Condition policy was included. 9. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all staff starting on 2/2/26 on Comprehensive Care Plan/Baseline Care Plan. The Baseline Care Plan was included. 10. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all staff starting on 2/2/26 on admission of residents. The admission of Resident Care Plan was included. 11. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all staff starting on 2/2/26 on the admission of Resident/Admission- readmission Checklist. The admission Checklist was included. 12. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced IDT starting on 2/2/26 on Comprehensive Care Plan. The Comprehensive Care Plan was included. 13. V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all staff starting on 2/2/26 on Infection Prevention and Control Program. The Infection Prevention and Control Program policy was included. 14. V14/Vice President of Operations In-Serviced Administration on Ensuring all New Admissions (referrals)- equipment and supplies are obtained prior to admission. 15. A QAPI Meeting was held with the medical director and IDT o discuss deficiencies and facility action plans. QAPI meeting notes were included. 16. A facility wide audit was started on 2/2/26 for all residents wound care plans. Updated Wound Care Plans were included. 17. A facility wide audit of residents with wounds were reviewed for any changes needed and the physician was updated. A Wound Report was included. 18. The facility will conduct audits (seven days per week for six weeks) for all residents with pressure injuries. The audits were included. On 2/9/26 at 12:50 PM V47/Agency Licensed Practical Nurse stated on 2/2/26 she was supposed to do all the skin sweeps for the abatement plan but stated she did not get to everyone. V47 stated she was the only nurse on the tracheostomy/ventilator unit and could not get to all the residents to check their skin. V47 also stated she was given a paper to sign to sign for in-services, but stated she was not educated on them. On 2/9/26 at 2:15 PM V14/Corporate [NAME] President of Operations verified the skin checks for all residents were not completed on 2/2/26 and they were starting to work on all skin sheets now. On 2/9/26 at 3:06 PM V51/Agency stated she was not in-serviced by anyone at the facility regarding the above topics in the abatement plan. Based on observation, interview, and record reviews conducted on 2/10/26 the facility completed all (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	measures on the abatement plan, including providing in-servicing all of the staff on abuse and dementia policies. Therefore, the abatement plan could be approved on 2/10/26.

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F 0689 Level of Harm - Minimal harm or potential for 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 resident falls were investigated and care planned, develop new interventions after falling, and ensure existing fall interventions were implemented for three of four residents (R1, R7, R9) reviewed for falls in the sample of 16.Findings include:The facility's Fall Prevention Program policy, dated 11/21/17, documents To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Components include Notification of physician, family/legal representative, care plan incorporates; identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, preventative measures. Safety interventions will be implemented for each resident identified at risk. Accident/Incident reports involving falls will be reviewed by the interdisciplinary team to ensure appropriate care and services were provided and determine possible safety interventions. The Director of Nursing or designee is responsible for monitoring the fall prevention program, including further staff education programs, purchase of additional equipment, or other appropriate environmental alterations.1. R1's current Care Plan, dated 1/20/26, documents R1 was admitted to the facility on [DATE] with multiple diagnoses including Lung Cancer, Brain Cancer, Failure to Thrive, Muscle Wasting and Atrophy, and Abnormalities of Gait and Mobility. This care plan documents I have an ADL (Activities of Daily Living) self-care performance deficit with a varying level of assistance needed related to Metastatic Lung cancer with Bone and Brain involvement, Cancer Pain, history of TBI (Traumatic Brain Injury). This care plan also documents R1 requires substantial/maximal assistance with toileting, transferring, and sitting. This same care plan documents I am at risk for falls related to Metastatic Lung Cancer with Brain Metastasis, Malnutrition, history of TBI (traumatic brain injury), Seizures. Date Initiated: 12/31/2025. Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair.R1's nursing progress notes, dated 12/28/25 at 12:45 PM, documents Resident had a witnessed fall 12/28/2025 at 12:00 PM. Location of Fall: hallway (R1) was wheeling himself in wheelchair and scooted himself out of chair.R1's nursing progress notes, dated 12/28/25-1/18/26, document R1 suffered four falls in the three-week time frame.On 1/28/26 at 10:40 AM, R1 was sitting in his room in a wheelchair. R1's call light was across the room by R1's bed and R1 was facing the doorway near the entrance to his restroom. R1's bare feet were on the floor without any socks or footwear. At this time, R1 stated he needs to use the restroom and is wanting his nurse. 2. R7's current Care Plan, dated 3/28/25, documents The resident review shows high risk for falls. Risk Factors include cognitive impairment/does not understand limits, confusion, incontinence, use of assistive device, age, impaired judgment/poor safety awareness, decreased muscle coordination history of falls, and side effects of medication use. Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.R7's nursing progress notes, dated 12/18/25 at 3:38 AM, documents R7 suffered an unwitnessed fall in her room, and a new intervention was added for nonskid footwear.R7's current care plan does not document a new intervention after R7's fall on 12/18/25.On 1/29/26 at 1:15 PM, R7 was sitting in her recliner in her room. R7 didn't have a call light within reach. When observing the room, the room only had one cord that was going towards a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	different bed. On 1/29/26 at 1:17 PM, V49 (Certified Nursing Assistant) verified that R7 did not have a call light on her side of the room or within reach. V49 stated (R7) does not have a call light and I don't know why. She should have one and she can use it.3. R9's current Care Plan, dated 12/16/25, documents R9 has diagnoses including but not limited to Tracheostomy status, Gastrostomy status, Critical illness Myopathy, Pressure ulcer of Sacral region, stage IV (four), and Type two Diabetes. This care plan documents I have a history of falls and am a fall risk at this time. I need my bed lowered and utilize floor mats to ensure my safety. Interventions: document when (R9) falls on (electronic record), report any falls to the nurse and DON (Director of Nursing).R9's nursing progress notes, dated 12/30/25 at 12:41PM, documents Behavior Note: Resident was observed attempting to ambulate out of bed without assistance. During the attempt, the rectal tube became dislodged and was removed. No active bleeding noted at the time. Perineal assessed and cleaned. Physician notified. Will continue to monitor.R9's progress note, dated 12/30/25 at 7:57 PM and completed by V30 (Facility Nurse Practitioner), documents Patient found this morning, halfway out of bed, appears to have slide out of bed. Bed was low to the floor, shoulders and above in bed, buttocks and legs on floor, with stool on the floor, rectal tube pulled out.R9's electronic medical record does not document that a fall investigation was completed for R9's fall on 12/30/25.R9's care plan does not document any revisions or updated fall interventions after R9's fall on 12/30/25.On 2/10/26 at 1:00 PM, V4 (Assistant Director of Nursing) confirmed R1, R7 and R9 are all at risk of falling and have suffered falls in the past three months. V4 stated (R1) should be always wearing non-slip footwear when up in his chair, not barefoot. (R7's) fall on 12/18/25 should have had a new intervention added to the care plan. I am not aware why the notes would say non-skid footwear for her intervention. I'm not aware of where that came from, and I don't recall having a meeting or completing the investigation for that fall. (R7) should have an update to her care plan and I do not see that either. (R7) would not benefit from non-skid/slip footwear because she does not ambulate on her own. I do not see any investigation or fall notes related to (R9's) fall on 12/30/25. He does not have any new interventions on the care plan or an updated fall assessment, and those things should have been done.

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F 0692 Level of Harm - Minimal harm or potential for 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 Interview and Record review, the facility failed to complete physician ordered weights for two of three residents (R1, R9) reviewed for nutrition in the sample of 16.Findings include:The facility's Weights policy, dated 10/17/19, documents Each resident shall be weighed on admission and at least monthly thereafter, or in accordance with Physician orders or plan of care. Residents identified at nutritional risk may be weighed weekly or bi-weekly as per physician order or interdisciplinary team recommendation.1. R1's current Care Plan, dated 1/20/26, documents R1 was admitted to the facility on [DATE] with multiple diagnoses including Lung Cancer, Brain Cancer, Chronic Kidney disease, Failure to Thrive, Muscle Wasting and Atrophy, and Severe Protein-Calorie Malnutrition.R1's Medication Administration Record (MAR), dated 12/1/25-12/31/25, documents R1 had a physician order started on 12/4/25 for height and weight upon admission on e time for height and weight daily for seven days. This same record documents R1's weight was recorded on 12/4/25 and does not document any other weights for the month of December.2. R9's Care Plan, dated 12/16/25, documents R9 has diagnoses including but not limited to Tracheostomy status, Gastrostomy status, Critical illness Myopathy, Pressure ulcer of Sacral region, stage IV (four), and Type two Diabetes. This care plan documents I require tube feeding Osmolyte 1.5 to infuse at 70 milliliters an hour for 22 hours, starting daily at 5:00 AM. Interventions: See Physician orders for current feeding orders. Obtain and monitor lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated. RD (registered dietician) to evaluate quarterly and as needed.R9's Physician Order Summary (POS), dated 11/20/25-2/10/26, documents R9 had a physician order started on 11/20/25 for height and weight upon admission on e time for height and weight daily for seven days.R9's Weights and Vitals summary, dated 2/10/26, documents R9 was weighed on 11/21/25 and not weighed again until 12/31/25.R9's nutrition progress note, dated 12/29/25 at 6:13 PM, documents the last weight on R9 was recorded on 11/21/25.On 2/10/26 at 1:00 PM, V4 (Assistant Director of Nursing) confirmed R1 and R9 did not have their weight completed as ordered. V4 stated (R1) and (R9) had orders for daily weights after admission for seven days and neither resident had those completed. I see a weight for R9 on admission and then not again until about a month later.

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Goldwater Care Peoria Heights	5533 North Galena Road Peoria Heights, IL 61614

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide physician ordered gastrostomy care including cleansing, laboratory monitoring, flushes, residual checks and tube insertion site assessments for a resident with an internal percutaneous endoscopic gastrostomy (PEG) tube for nutritional support for one of three residents (R9) reviewed for gastrostomy tubes (G-tube) in the sample of 16. This failure resulted in R9 transferring to the emergency room and being admitted to the hospital with fever, abdominal pain, diarrhea, nausea and vomiting, toxic appearance and a diagnosis of sepsis from multiple suspected sources including a g-tube site infection with pus filled drainage.These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy started on 11/22/25 when R9's scheduled gastrostomy tube cares were not completed. V1 (Administrator in Training) and V2 (acting Director of Nursing) were notified of the Immediate Jeopardy on 2/4/26 at 9:30 AM. While the immediacy was removed on 2/10/26, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.Findings include:The facility's Gastrostomy Tube- Feeding and Care policy, dated 8/3/20, documents Purpose to provide nutrients, fluids and medications, as per physician orders, to residents requiring feeding through an artificial opening into the stomach. Measurement of gastric residual is usually ordered for new g-tube placement/ feeding and before advancing the hourly feeding rate to determine resident's tolerance to feeding of to detect complications related to gastric emptying and absorption. Observe the resident for signs and symptoms of nausea, vomiting, diarrhea, abdominal distention/ cramping. Notify physician. This same policy documents Stoma site care. Inspect the surrounding skin for redness, tenderness, swelling, irritation, purulent drainage, or gastric leakage; immediately report skin irritation or infection and provide treatment. Clean skin with soap and water or antiseptic of choice. Begin next to stoma site, using spiral pattern and moving outward, clean under skin disk with cotton swab. Dry thoroughly; leave area open to air to minimize dampness, skin irritation, and maceration; use a dressing only if ordered.R9's Care Plan, dated 12/16/25, documents R9 has diagnoses including but not limited to Tracheostomy status, Gastrostomy status, Critical illness Myopathy, Pressure ulcer of Sacral region, stage IV (four), Osteomyelitis of vertebra, Sacral and Sacrococcygeal region. This care plan documents I require tube feeding Osmolyte 1.5 to infuse at 70 milliliters an hour for 22 hours, starting daily at 5:00 AM. Interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record. I am dependent with tube feeding and water flushes. See Physician orders for current feeding orders. Obtain and monitor lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated.R9's Physician Order Summary (POS), documents R9 was admitted to the facility on [DATE] with treatment orders for R9's G-tube site care to cleanse and apply split gauze every shift for infection control and a treatment to check residual before medications and feedings, if greater than 100 (milliliters) hold feeding and medications and notify physician every shift and an order. This order was not initiated until 11/25/25 (five days after admission). This summary also documents R9 has an order starting on 12/24/25 to cleanse g-tube insertion site everyday with soap and water during ADL (Activities of Daily Living) care, every shift for g-tube.R9's Treatment Administration Record (TAR), dated 11/20/25-11/30/25, documents R9 did not receive g-tube site cleaning and new gauze on 11/22/25 evening shift. This TAR also documents R9 did not have any g-tube residual monitoring from 11/20-11/25/25 prior to feeding and medication administrations.R9's Treatment Administration Record (TAR), dated 12/1/25-12/31/25, documents R9 did not receive scheduled (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	g-tube site cleaning and new gauze on seven occasions and was not provided scheduled g-tube residual monitoring on nine occasions. This same record also documents three scheduled soap and water cleansings of R9's g-tube site were not completed from 12/24-12/31/25.R9's Medication Administration Record (MAR), dated 12/1/25-12/31/25, documents an order for enteral feed flush to flush with 30 milliliters (ml) of water before giving medications, flush with at least five ml between medications, and flush with a minimum of 30 ml after all medications given. This MAR documents R9's g-tube was not flushed on day shift on 12/5/25 and on evening shift in 12/29/25.R9's Treatment Administration Record (TAR), dated 1/1/26-1/31/26, documents from 1/1-1/17/26, R9 was not provided g-tube site cleaning and new gauze on seven occasions, was not provided scheduled g-tube residual monitoring on seven occasions and scheduled soap and water cleansings of R9's g-tube site were not completed on six occasions.R9's nursing progress note, dated 1/1/26 at 10:23 PM, documents Resident rectal tube fell out. Called MD (V22, Facility Medical Director) and he said to monitor and call the surgeon (unknown gastric surgeon). This nurse could not find surgeon's number. DON (V2, Director of Nursing) notified, care ongoing.R9's progress notes, dated 1/1/26- 1/17/26, does not document a gastric surgeon was notified of R9's rectal tube removal and does not document that the rectal tube was ever replaced.R9's nursing progress note, dated 1/6/26 at 9:45 AM, documents Residents POA (Power of Attorney, V32) requested that a new rectal tube be placed. Reported to APN (Advance Practice Nurse, V30) in facility. States (V30) will check and see if we can order one and speak with (V32) about this. No concerns at this time.R9's nursing progress note, dated 1/12/26 at 9:55 AM, documents Got in report that (R9) has had emesis last night into this AM. Feeding shut off for two hours.R9's progress note, dated 1/13/26 at 11:44 PM and completed by V30, documents Patient has had vomiting two nights ago, last evening at 6 PM and this morning at 6 AM. Vomiting on three occasions over the past two days. Monitor for improvement in symptoms or for any worsening.R9's nursing progress note, dated 1/14/26 at 9:53 AM, documents (R9) had emesis this (morning) at 7:35 AM. Feeding paused at this time Zofran (nausea medication) given for nausea. Will continue to monitor.R9's progress note, dated 1/16/26 at 5:41 PM and completed by V30, documents (R9) had another episode of vomiting this AM, nursing states (R9) has had vomiting for the past three to four days. He has metoclopramide (antiemetic medication) ordered on a schedule and ondansetron (nausea medication) as needed. This progress notes also documents diarrhea is also being reported to V30.R9's nursing progress note, dated 1/17/26 at 9:54 AM, documents G-tube leakage noted. (V22, Facility's Medical Director) notified. Orders for CBC (Complete Blood Count), BMP (Basic Metabolic Panel), and KUB (Kidney Ureter Bladder imaging). Will continue to monitor.R9's electronic medical record does not document that R9 had a CBC or BMP drawn or laboratory (lab) results were received.On 1/30/26 at 1:22 PM, V4 (Assistant Director of Nursing) confirmed R9 does not have results for a CBC or BMP. V4 stated (R9) does not have any lab results because none were completed at the facility, only at the hospital.R9's Nursing Progress note, dated 1/17/2026 at 8:00 PM, documents (V22) ordered a KUB due to leaking g-tube. KUB results came back with no clear results due to faulty imaging. (V32, R9's family) came for a visit. Resident's feed has been turned off by day-shift nurse due to leaking. (V32) came to this nurse and wanted a re-assessment. Upon assessment, tube drain and gown were soaked with feed, took tube drain off and had a slight yellow-pink color to it mixed with feed. G-tube site kept continuously leaking feed. Resident complained of no abdominal pain, or pain anywhere else. (V23) wanted (R9) sent to be evaluated due to no clear results from KUB imaging. Resident sent to (local hospital ER) per request of (V32). (V22) aware.R9's Hospital admission record, dated 1/17/26, documents R9 was admitted to the hospital with fever, abdominal pain, diarrhea, nausea and vomiting, toxic appearance and a diagnosis of sepsis from multiple suspected sources (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	including g-tube site infection with pus leaking drainage. On 1/28/26 at 12:40 PM V32 (R9's family member) stated Saturday (1/17/26) when he was taken to the hospital I went in there and his belly was covered with crust. Feeding was coming out of his stomach. Then when I lifted the gauze there was yellow puss coming out of his belly. I told the nurse that he needed to go to the hospital. It was awful. (R9's) g-tube was not cared for correctly. The feeding tube was removed in the hospital due to an abscess and sepsis.On 1/29/26 at 12:15 PM, V22 (Facility's Medical Director) confirmed he wanted R9's surgeon notified when his rectal tube came out (1/1/26), due to potential concerns with the bowel. V22 stated I wanted (R9) to follow up with the GI (gastrointestinal) surgeon (unknown) due to the G-tube and worried about the bowel and possible placement issues with that. So, I did want the surgeon notified when it came out. I have not been notified that there is such an issue (in the facility) with missing treatments, missing medications and care concerns.On 1/29/26 at 12:50 PM, V33 (emergency room (ER) Physician) stated I saw (R9) in the hospital. He is a very sick person and it's unfortunate. When we admitted him for the second time for Sepsis (1/17/26) we had him in the ER for a longer period. Any tube coming out of the body has the potential to get infected. At the time of his admission, we also were concerned with his g-tube site with purulent pus like drainage which can relate to the sepsis. If you don't take care of the g-tube properly with cleansing and flushes, then you can get infection at the site. Additionally, if the feeding is going into the abdominal cavity due to becoming dislodged it also is a risk factor for that becoming infected. I believe the g-tube was removed by gastrointestinal surgeons while in the hospital.On 2/4/26 at 9:30 AM, V2 (acting Director of Nursing) confirmed she reviewed R9's hospital admission and electronic records and stated she was unaware that R9 was not receiving adequate g-tube care. V2 stated she cannot provide documentation to show a gastric surgeon was notified after R9's rectal tube came out.On 2/10/26 this surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:1. On 2/9/26 all licensed nurses were educated on the facility's complete Gastrostomy Tube - Feeding and Care policy by V2 (Director of Nursing), V3 (Minimum Data Set coordinator), and V4 (Assistant Director of Nursing/ Wound Nurse).2. On 2/9/26 all licensed nurses were educated on the facility's Physician Orders - Entering and Processing policy including but limited to when receiving, entering, and confirming physician or prescriber's orders the order is entered into the resident's chart under EMR (electronic medical record) by V2 (Director of Nursing) and V4 (Assistant Director of Nursing/ Wound Nurse).3. On 2/9/26 all licensed nurses were educated on the facility's Documentation - Electronic Health Record policy including but not limited to entries made in the electronic health record shall be timely, accurate, relevant, and complete by V2 (Director of Nursing/Designee) or V1 (Administrator).4. On 2/9/26 all licensed nurses were educated on the facility's Skin Condition Assessment & Monitoring - Pressure and Non- Pressure policy by V2 (Director of Nursing/Designee) or V1 (Administrator).5. On 2/9/26 all licensed and certified nursing assistants were educated on the facility's Physician-Family Notification - Change in Condition policy by V2 (Director of Nursing/Designee) or V1 (Administrator).6. On 2/9/26 an impromptu QAPI meeting was held with medical director and staff IDT team to discuss deficiency and facility action plan.7. On 2/4/26 a facility wide audit of all residents' who have gastrostomy tubes to ensure stoma site have a treatment order in place, tube feeding orders are in place in the EHR, residual check in on the resident's MAR for prior to water flushes, medication administration and bolus feeding or a start of new bottle through feeding pump, and signs/symptoms of nausea, vomiting, distended abdomen, cramping, sluggish or absent bowel sounds, dry heaves/retching and cold sweats the physician has been notified and is documented in the EHR. Any skin abnormalities at stoma site, the characteristics are documented and (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physician notified and documented; care plans for those individuals have been reviewed and all interventions are in place and updated on the resident's treatment administration record (TAR) by the nurse by the V2 (Director of Nursing/Designee).8. The facility will conduct audits (7 days per week for 6 weeks) to ensure resident who have ensure stoma site have a treatment order in place and TAR is signed off for completion, tube feeding orders are in place in the EHR, residual check in on the resident's MAR for prior to water flushes, medication administration and bolus feeding or a start of new bottle through feeding pump, and signs/symptoms of nausea, vomiting, distended abdomen, cramping, sluggish or absent bowel sounds, dry heaves/retching and cold sweats the physician has been notified and is documented in the EHR. Any skin abnormalities at stoma site, the characteristics are documented and physician notified and documented by the nurse. A QA tool -will be completed to verify this practice has occurred. The QA tool will be completed by V2 (DON) or designee, daily for 6 weeks. This started on 2/4/26 and is ongoing.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to administer prescribed opioid medications to keep a residents' pain controlled, failed to perform pain assessments and implement pain relieving interventions while the resident was not receiving their prescribed pain relieving opioid medication, and failed to notify the physician of the need for a opioid medication refill order and complaints of increased pain for one of three residents (R2) reviewed for pain in the sample of 16. These failures resulted in R2 experiencing restlessness and unrelieved excruciating pain after five days of going without her prescribed pain medication.Findings include:The facility's Pain Management Policy, dated 7/6/18, documents Purpose: To establish a program which can effectively manage pain in order to remove adverse physiological and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. Guidelines: It is the goal of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facility life involvement. The purpose of this policy is to accomplish that goal through an effective pain management program. Definition: The resident's descriptive words regarding the quality, duration, and location not pain will be used to evaluate the pain and to identify changes in pain. When the resident is unable to describe pain, physical signs such as grimacing, body posturing/protecting, vital signs change, and changes in behavior and mood will be used to determine the presence of pain. The pain management program includes the following components: Documentation of pain assessment and monitoring. Standards: 1. Pain assessment protocol will be initiated under any of the following situations: a. Any indication of pain based on the pain assessment performed for each resident at the time of admission and with any condition change and/or incident associated with the potential of pain. c. Resident receives routine pain medication and/or pain is controlled.The facility's Pain Assessment Policy, dated 7/6/2018, documents Purpose: To establish guidelines for appropriate assessment and intervention to manage pain. To respect and support the residents' right to optimal pain management. To measure and document the effectiveness of the plan using objective and subjective assessment criteria. Responsibility: Licensed Nurse. Guidelines: 1. A pain assessment tool will be used as indicated as a guide in determining a resident's pain level in addition to their descriptive words, and/or physician signs and behaviors. 2. A pain assessment will be performed as part of the admission assessment. A pain assessment may be completed as indicated by diagnosis and other events during the residents' stay may initiate additional pain assessments (Example: Post falls or new diagnosis of compression fractures, etcetera.) 3. Prior to administration of PRN (as needed) pain medications, non-pharmacological interventions will be attempted if patient is responsive and willing. Medications will be administered at the specific request of the patient and when the patient refuses other such interventions.The facility's Medication Administration General Guidelines Policy, undated, documents Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). Administration: 2. Medications are administered in accordance with written orders of the prescriber.R2's Physician Order Report documents R2 was admitted on [DATE] with the diagnoses of Age-related Osteoporosis, Restless Leg Syndrome, Anxiety Disorder, Periprosthetic Fracture around Prosthetic Left Knee Joint, Type Two Diabetes Mellitus, Fibromyalgia, Depression, Unspecified Fracture of Lower End of Left Femur, Other Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy, Other Lack of Coordination, Complex Regional Pain (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Syndrome of Upper Limb, and Major Depressive Disorder. This same Physician Order Report documents, Start Date: 10/28/25- Hydrocodone-Acetaminophen 5-325mg (Milligrams) one tablet every six hours for pain management.R2's Care Plan dated 10/26/25 documents Potential for pain related to recent fracture, recent surgery, and fibromyalgia. Approach: Administer medications as ordered. Assess for signs of pain. Notify Doctor if pain medications are ineffective. This same care plan documents R2 has a history of Periprostatic fracture and to administer pain medications as ordered.R2's MAR (Medication Administration Record), dated October 24th, 2025, through October 31st, 2025, documents R2's scheduled Norco-Acetaminophen 5-325mg was not administered on 10/31/25 at 8:00 PM.R2's Order's Administration Note written by V37/LPN (Licensed Practical Nurse) dated 11/1/25 at 1:05 AM, documents Hydrocodone-Acetaminophen Oral Tablet 5-325mg. Give one tablet by mouth every six hours for Pain Max Acetaminophen 3 gm (grams)/24 hours. Medication unavailable in cart.R2's MAR, dated November 1st, 2025, through November 4th, 2025, documents R2's scheduled Norco-Acetaminophen 5-325mg were not administered for 12 out of the 12 doses ordered.R2's Order's Administration Notes, dated 11/1/25 through 11/4/25, documents Hydrocodone-Acetaminophen Oral Tablet 5-325mg. Give one tablet by mouth every six hours for Pain Max Acetaminophen 3 gm (grams)/24 hours. Medication on order.R2's Health Status Note, written by V23/LPN on 11/2/25 at 10:36 AM, documents (R2) is out of Hydrocodone, prescription faxed to (V22/R2's Physician), awaiting refill.R2's Electronic Medical Record does not include any pain-relieving interventions, physician's notification of R2 not receiving the prescribed pain medication, or comprehensive pain assessments after the 13 occasions between 10/31/25 and 11/4/25 when R2 did not receive her Norco as prescribed.On 1/27/26 at 9:29 AM R2 stated she had a fall at home around a month prior to her admission to the facility and ended up having a left leg fracture resulting in R2 being hospitalized . R2 stated, I was in severe pain and needed therapy and pain management at the facility. When I was admitted to the facility, I was not receiving enough pain medication to control my pain. My doctor had ordered an increase in my pain medication. I received my pain medication for a few days, but at the end of October to early November 2025, the facility kept telling me I was out of my pain medication, and the doctor needed to sign some kind of script in order for my pain medication to be refilled. I was in severe pain and crying out and the staff would tell me there was nothing they could do, so they just assigned me to an ombudsman to speak with. I could not move on my own, I was in severe pain, I could not get comfortable, and the staff did nothing during the time I had no pain medication. It messed with me psychologically and was more than what I could handle, so when I was sent out to the hospital eventually, I requested to not return to the facility.On 1/27/26 at 12:47 PM V35/LPN (Licensed Practical Nurse) stated I was working at the facility when (R2) was a resident. (R2) was able to make her needs very known I do know (R2) was not receiving her pain medications like (R2) should have been and was always complaining of pain in her left leg especially. I know there was a change in prescription with (R2's) pain medication in the beginning, and after that change, pharmacy kept saying (R2's) Norco was on hold. I am not aware if (R2) received any other pain-relieving interventions during the time her Norco (Hydrocodone-Acetaminophen) was out.On 1/27/26 at 1:02 PM V1/Administrator-in-Training stated, I know at one time (R2) had filed a grievance stating the facility was out of her pain medication and that she was in pain. I know at that time we were waiting for (R2's) prescription to be filled. (R2) was not happy with the response, but we (the facility) had to wait for the pharmacy to fill it. (R2) should not have gone without her pain medication.On 1/28/26 at 2:02 PM V22/Facility Medical Director stated he expects the facility to notify him if a resident's pain medication is not being refilled by the pharmacy. V22 can then prescribe an alternative pain relief. V22 stated, (R2) should not have gone without her scheduled pain medication given (R2's) (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	condition. The facility should have gotten ahold of me when they realized (R2's) Norco was out and the pharmacy was stating it was on hold. I am always available by phone call.On 1/29/26 at 11:43 AM V52/LPN stated, (R2) complained of all over pain quite frequently when I worked with her.On 1/29/26 at 1:23 PM V30/Facility Nurse Practitioner stated she does recall R2 complaining of pain quite frequently and stated if the facility had an issue with getting R2's pain medication from the pharmacy she would have expected them to notify her or V22/Facility's Medical Director to get an order for something else to give R2 for the pain while awaiting the refill. On 1/29/26 at 2:03 PM V2/Corporate/Interim Director of Nursing verified that R2 missed all scheduled doses of Hydrocodone from the evening of October 31, 2026, through November 4, 2026, and did not receive any PRN (as needed) pain medication or pain interventions during that same time. V2 stated that if a resident's pain medication is unavailable, nursing staff are expected to contact the pharmacy immediately to determine the delivery schedule of the medication that is unavailable, utilize backup supplies if the delivery for the unavailable medication does not arrive the same day, and/or coordinate with the physician for a local pharmacy script if the unavailable medication is not in the facility's backup stock, ensuring there is no gap in administration. V2 verified R2's progress notes dated 10/31/25 through 11/4/25 documented R2's Norco was on hold but did not have any documentation of the nurses notifying any physician to get R2's Norco delivered the same day or get something alternative ordered.On 2/3/26 at 10:43 AM V6/Occupational Therapist stated, I only worked with (R2) once, but she was very cooperative. (R2) complained of pain during that session. (R2) had diagnoses that supported why (R2) would be in severe pain. It seemed like (R2) was in the most pain when being moved.On 2/10/26 at 12:05 PM V3/MDS Coordinator stated, The floor nurses are assigned to perform an electronic pain assessment on a resident when they are admitted to the facility or during any acute change in condition. I do not see where anyone performed a pain assessment at any time during (R2's) admission to the facility. That would have helped the staff respond appropriately to (R2's) pain and try alternatives to relieve (R2's) pain when (R2) was out of her pain medication.

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Goldwater Care Peoria Heights	5533 North Galena Road Peoria Heights, IL 61614

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews, the facility failed to ensure sufficient staff were available to meet the needs of the residents. This failure has the potential to affect all 53 residents currently residing at the facility.Findings include:The facility's Daily Census Report, dated 1/26/26, documents 53 residents reside in the facility.The Facility Assessment Tool, dated 11/1/25, documents The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided with care that allows the resident to maintain or attain their highest practical physical, mental, and psychosocial well-being. Facility resources needed to provide competent support and care for our resident population on a daily basis and during emergencies: Staffing Plan- staff- Licensed Nurses: RN (Registered Nurse), LPN (Licensed Practical Nurse), providing direct care. Plan: Total number of Licensed Nurses staffed per shift on average: Day shift-2, Night shift-2. CNA's (Certified Nursing Assistants) provide direct care. Plan: Total number of CNA's staffed per shift on average (Includes Restorative Aides): Day shift-5, Evening Shift- 5, Night Shift- 3. This same Assessment documents all residents residing within the facility require assistance with Activities of Daily Living.The facility's Call Light Policy, dated 2/2/18, documents Purpose: To respond to resident's requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in a timely manner. 2. All staff should assist in answering call lights. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered. Procedure: 1. Answer light (signal) promptly.The facility's Certified Nursing Assistant Job Description, dated 5/2/17, documents Certified Nursing Assistant: Summary- The CNA (Certified Nursing Assistant) is responsible for providing resident care and support in all activities of daily living and ensures the health, welfare, and safety of all residents. Essential Duties and Responsibilities: Provide for resident comfort by utilizing resources and materials; answering call lights and requests; reporting observation of the residents to the nursing supervisor.A Resident Council Meeting, dated 9/30/25, documents Residents state concerns reported with passing ice water. Residents also state long waits for staff to come serve.A Resident Council Meeting, dated 12/30/25, documents Nursing: better customer service when answering call lights and following through with resident requests or needs.On 1/27/26 at 10:15 AM, R6 was lying in bed. V9/R6's Grandmother/Guardian stated, (R6) is supposed to be cleaned up and turned every two hours. I go out and make sure they come do that. If I don't remind them, it will vary from three to five hours sometimes and it's questionable if it happens at all. I am the building with (R6) every day and night. V19 also stated, Look, (R6) has two (disposable briefs) on right now. The staff rip off the wings to one (disposable brief) and use it as a liner and then they put a second (disposable brief) over it, so they don't have to change (R6) as frequently due to low staffing. R6 was observed with two disposable briefs on at this time.On 1/27/26 at 12:02 PM V17/Ombudsman stated every month during resident council the residents complain of call light waiting times. V17 stated, You can speak with (R15/Resident Council President), she is aware of the residents' concerns with staffing.On 1/27/26 at 1:29 PM R2 stated, I laid in poop and pee for hours before any staff would answer my call lights at the facility. I was able to use the bed pan. If staff didn't answer my call light timely, I would have an accident and lay in my own poop and pee. Sometimes I would wait more than two and a half hours before someone could clean me up. I (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was so embarrassed and ashamed to lay in my own poop and pee that long. If the staff did get me on the bed pan in time, the staff wouldn't come back and take me off the bed pan, leaving me sitting on the bed pan for sometimes two hours. It was very painful. I came to the facility after I had surgery and was completely helpless and relied on staff to provide me with care. They would not get me up out of bed because it took two of them and they would say they didn't have enough staff to get me up and then put me back to bed later. It caused me complete embarrassment and humiliation along with disgust. In my opinion that facility should be shut down. R2 reported staff would always say they did not have enough staff to change everyone timely on their shift.On 1/29/26 at 11:43 AM V52/LPN stated she works on an as needed basis. V52 stated, I was picking up shifts twice a week, then I went to one shift per week December 2025 and January 2026. Now I am only picking up once a shift every pay period. They (management) do not schedule enough staff on dayshift to be able to take care of everyone appropriately. I was like a [NAME] on dayshift and management wanted me to do things for them along with my own things. There were not enough of us and CNA's to appropriately take care of the residents.On 1/29/26 at 12:38 PM V1/Administrator-in-Training stated the facility staffs CNAs based on the facility assessment. V1 stated, The facility assessment states we (the facility) will staff five CNAs on dayshift, five CNAs on evening shifts, and two CNAs on night shifts. CNAs work eight-hour shifts so that would be a total of 104 hours of CNA direct care staff needed daily. The facility assessment takes into account the acuity of care required for the residents.On 1/30/26 at 2:55 PM, V14/Corporate [NAME] President of Operations submitted nursing staffing data covering 1/5/25, 1/6/25, 1/27,25, and 1/3/26. The spreadsheets detailed total hours worked by both facility and agency staff, with daily CNA totals as follows: 12/5/25 totaled 80.25 CNA hours worked, 12/6/25 totaled 80.25 hours worked, 12/27/25 totaled 73.5 hours worked, and 1/3/26 totaled 73.75 hours worked. According to the staffing spreadsheets provided on 12/5/25, 12/6/25, 12/27/25, and 1/3/26, the facility did not meet the required 104 hours needed for CNA direct care hours.On 2/3/26 at 12:35 PM, V43/CNA stated that she has worked on and off at the facility for 15 years but will never step a foot back in the building since they have gotten new management. The staffing is absolutely horrible. Evenings will have two to three CNAs working. There have been times when there was only one CNA and one nurse on nights. Call lights are not answered timely. It can take an hour or longer. Residents were put in double disposable briefs, so they did not need changed as often. V43 also stated, When we say we are short on staff management says, we need to make it work. The administrator and DON's (Director of Nursing's) doors are always closed. There is no DON now and (V2/Corporate Interim DON) only comes in once a week to give write ups. I got a write up because I was not taking my lunch. I didn't have time to take lunch because we were short staffed. Just because there may be enough CNAs in the building if they are agency they are not as efficient, and we are not able to give the residents the care they deserve.On 2/3/26 at 1:00 PM, V42/CNA stated she has worked at the facility for about six months. The facility does not have enough staff to take care of the residents. Agency is used a lot. Evening shift has three regular staff plus agency staff and nights has two CNAs plus agency staff. Nurses do the best they can.On 2/10/26 at 12:58 PM R16 stated that the last four resident council meetings residents have complained about their call lights not getting answered timely and having to sit in urine and poop for long periods of time. R16 also stated The resident's state that it's more on second and third shift that staffing is short. The staff will tell them they (staff) don't have enough staff to get to everyone timely. On 2/10/26 from 1:02 PM to 1:36 PM, R15's call light remained on during this time.On 2/10/26 at 1:37 PM R15 was lying in his room with the covers pulled down and had on a disposable brief. R15 stated, A CNA (Unknown) came in around 25 minutes ago and asked what I needed. I told (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	them I was wet and had pooped and I needed to be changed. The CNA told me she was going to go get washcloths and be right back. She never returned. This happens all the time and makes me feel disgusted and like h*ll. My call light has been on for at least thirty to forty minutes, and I have had to sit in my own poop. Last Sunday I pooped and peed in my bed, turned on my call light around 3:30 PM and sat there until 6:30 PM until a staff member came to my room. My butt was burning and sore. Staff always say, We don't have enough staff, so you will have to wait until we get to you. R15 also stated that his call light had been on for at least thirty to forty minutes.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, it was determined that the facility failed to ensure that all Certified Nursing Assistants (CNAs) received 12 hours of mandatory in-service training as required. These failures have the potential to affect all 53 residents residing within the facility. Findings include:The facility's Daily Census Report, dated 1/26/26, documents 53 residents reside in the facility.The Facility Assessment Tool, dated 11/1/25, documents Staff training/education and competencies: Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year.On 1/29/26 at 10:30 AM, V2/Corporate/Interim Director of Nursing stated, I cannot provide documentation to show that we provided 12 hours of training to any CNAs in the past year.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure scheduled physician ordered medications were given for four of six residents (R1, R2, R7, and R9) reviewed for medications in the sample of 16.Findings include:The facility's Ordering and Receiving Non-Controlled Medications, dated 6/2024, documents Policy: Medications and related products are received from the pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. The facility's Medication Administration General Guidelines Policy, undated, documents Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). Administration: 2. Medications are administered in accordance with written orders of the prescriber. Documentation (including electronic): 6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (Example: the resident is not in the facility at scheduled dose time or starter dose of antibiotic is needed), the space provided on the front of the MAR (Medication Administration Record) for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If three consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. The facility's RN (Registered Nurse) Job Description, dated 5/2/17, documents Summary: The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day activities performed by the nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times. Essential Duties and Responsibilities: Prepare and administer medications as ordered by the physician. The facility's LPN (Licensed Practical Nurse) Job Description, dated 5/2/17, documents Summary: The LPN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day activities performed by the nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times. Essential Duties and Responsibilities: Prepare and administer medications as ordered by the physician. The Ombudsman Residents' Rights Booklet dated 11/18, documents Your facility must provide services to keep your physical and mental health, at their highest practical levels. 1.R2's admission Record documents R2 is a [AGE] year-old female who admitted to the facility on [DATE] with the following but not limited to diagnoses: Periprosthetic Fracture around internal prosthetic left knee joint, Type 2 Diabetes Mellitus without Complications, Type Two Diabetes Mellitus, Unspecified Fracture of Lower End of Left Femur, Muscle Wasting and atrophy, Restless Leg Syndrome, Fibromyalgia, Age-Related Osteoporosis without current Pathological Fracture, and Other abnormalities. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's MDS (Minimum Data Set) dated 10/28/25 documents R2 is cognitively intact. R2's Care Plan documents, Problem: potential for pain related to recent fracture, recent surgery, and fibromyalgia. Interventions: Administer medications as ordered, assess for signs of pain, encourage (R2) to ask for pain medication at first sign of unrelieved pain. R2's Order Summary Report documents the following Physician Order: Hydrocodone-Acetaminophen (Schedule II controlled substance) 5-325mg (milligrams) give one tablet by mouth every six hours for Pain. R2's MAR (Medication Administration Record) dated October 1st, 2025, through October 31st, 2025, documents R2's scheduled Norco-Acetaminophen 5-325mg was not administered on 10/31/25 at 8:00PM. R2's Order's Administration Note written by V37/LPN (Licensed Practical Nurse) dated 11/1/25 at 1:05 AM, documents Hydrocodone-Acetaminophen Oral Tablet 5-325mg. Give one tablet by mouth every six hours for Pain Max Acetaminophen 3 gm (grams)/24 hours. Medication unavailable in cart. R2's MAR, dated November 1st, 2025, through November 4th, 2025, documented R2's scheduled Norco-Acetaminophen 5-325mg was not administered for 12 out of the 12 doses ordered. R2's Order's Administration Note written by V37/LPN dated 11/1/25 at 3:28 AM documents Hydrocodone-Acetaminophen Oral Tablet 5-325mg. Give one tablet by mouth every six hours for Pain Max Acetaminophen 3 gm (grams)/24 hours. Medication unavailable. R2's Order's Administration Notes, dated 11/1/25 through 11/4/25, documents Hydrocodone-Acetaminophen Oral Tablet 5-325mg. Give one tablet by mouth every six hours for Pain Max Acetaminophen 3 gm (grams)/24 hours. Medication on order. R2's Health Status Note, written by V23/LPN on 11/2/5 at 10:36 AM, documents (R2) is out of Hydrocodone, prescription faxed to (V22/R2's Physician), awaiting refill. On 1/27/26 at 9:29 AM R2 stated she had a fall at home around a month prior to her admission to the facility and ended up having a left leg fracture resulting in R2 being hospitalized . R2 stated, I was in severe pain and needed therapy and pain management at the facility. When I was admitted to the facility, I was not receiving enough pain medication to control my pain. My doctor had ordered for an increase in my pain medication. I received my pain medication for a few days, but at the end of October to early November 2025, the facility kept telling me I was out of my pain medication, and the doctor needed to sign some kind of script in order for my pain medication to be refilled. I was in severe pain and crying out and the staff would tell me there was nothing they could do. On 1/29/26 at 2:03 PM V2/Corporate/Interim Director of Nursing verified that R2 missed all scheduled doses of Hydrocodone from the evening of October 31, 2026, through November 4, 2026, and did not receive any PRN (as needed) pain medication during that same time. V2 stated that if a resident's pain medication is unavailable, nursing staff are expected to contact the pharmacy immediately to determine the delivery schedule of the medication that is unavailable, utilize backup supplies if the delivery for the unavailable medication does not arrive the same day, and/or coordinate with the physician for a local pharmacy script if the unavailable medication is not in the facility's backup stock, ensuring there is no gap in administration. V2 verified R2's progress notes dated 10/31/25 through 11/4/25 documented R2's Norco was on hold but did not have any documentation of the nurses notifying any physician to get R2's Norco delivered the same day or get something alternative ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R1's Medication Administration Record (MAR), dated 12/1/25-12/31/25, documents for the month of December, R1 did not receive 18 scheduled doses of physician ordered medications including Eliquis (anticoagulant), Juven (nutritional wound supplement), Zonisamide (anticonvulsant), Keppra (anticonvulsant), Metoprolol (antihypertensive), Vimpat (antiepileptic) and Modafinil (stimulant). These medications were left blank or document to see nurses notes. Follow up nursing notes for the unadministered medications document on order, not available. 3. R7's MAR, dated 2/1/26-2/28/26, documents R7 has a physician order for Prazosin (antihypertensive medication) one milligram (mg) by mouth every evening for antihypertensive. This record documents from 2/1/26-2/9/26, R7 did not receive the Prazosin six out of nine scheduled administrations. The follow up nursing notes for the unadministered doses of medication documents on order, awaiting pharmacy. 4. R9's progress note, dated 1/10/26 at 10:03 AM and completed by V30 (Facility Nurse Practitioner), documents Date of service 1/9/26. Assessment/Plan: Candidal stomatitis (oral yeast). [NAME] coating and patches noted on tongue. Nystatin (antifungal liquid) oral suspension, nursing to swab mouth QID (four times daily). Will monitor for improvement or worsening. R9's MAR, dated 1/1/26-1/31/26, documents R9 had an order for Nystatin suspension, give one swab orally four times a day for oral candidiasis, start date 1/9/26. This same MAR documents from 1/9/26-1/16/26, R9 did not receive 21 of 27 scheduled doses of Nystatin. These missed medication administrations were left blank or document to see nurses notes. Follow up nursing notes for the unadministered Nystatin document on order, not available. R9's progress note, dated 1/16/26 at 5:41 PM and completed by V30, documents White coating and patches noted on tongue. Nystatin oral suspension, nursing to swab mouth QID. Patient has not been receiving, still waiting on pharmacy. Will monitor for improvement or worsening. On 1/29/26 at 1:20 PM, V30 (Nurse Practitioner) stated I was not notified that they (the facility) couldn't get Nystatin oral for (R9) that I ordered on 1/9/26. I do remember being here a couple days later and I saw (R9's) mouth looked the same (white coated tongue). I remember asking then and the staff said it was still on order. On 2/9/26 at 12:50 PM, V47 (Agency Licensed Practical Nurse) stated she works in the facility often and there are often medications that are not available. V47 stated As far as my medication pass, there are always medications that are missing or on order. A lot of medication carts have medications that are out. I am not sure why they have such an issue with re-ordering medications, but it is common for them (the facility) to be out. On 2/10/26 at 1:00 PM, V4 (Assistant Director of Nursing) confirmed there are several residents who have been not getting scheduled medications. V4 stated We never had anyone auditing those things (medication administration) before this survey.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a resident was free of significant medication errors for two of three residents (R4 and R6) reviewed for significant medication errors in the sample of 16. Findings include:The facility's Medication Administration General Guidelines Policy, undated, documents Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). Administration: 2. Medications are administered in accordance with written orders of the prescriber. Documentation (including electronic): 6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (Example: the resident is not in the facility at scheduled dose time or starter dose of antibiotic is needed), the space provided on the front of the MAR (Medication Administration Record) for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If three consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response.The facility's RN (Registered Nurse) Job Description, dated 5/2/17, documents Summary: The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day activities performed by the nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times. Essential Duties and Responsibilities: Prepare and administer medications as ordered by the physician.The facility's LPN (Licensed Practical Nurse) Job Description, dated 5/2/17, documents Summary: The LPN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day activities performed by the nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times. Essential Duties and Responsibilities: Prepare and administer medications as ordered by the physician.The Ombudsman Residents' Rights Booklet dated 11/18, documents Your facility must provide services to keep your physical and mental health, at their highest practical levels.1. R4's computerized Medical Record documents that R4 is a [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Failure with Hypoxia, Tracheostomy Status, Gastrostomy Status, and Encephalopathy. R4's Care Plan documents I am on anti-convulsant/anti-seizure medication per order r/t (related to) TBI (Traumatic Brain Injury) Encephalopathy. Interventions -Administer Anti-convulsant/anti-seizure medication as ordered by physician. This same Care plan documents I have altered cardiovascular status r/t Dilated Cardiomyopathy, recent Cardiac Arrest. Intervention- Medications as ordered.R4's MAR dated December 2025 documents Vimpat Oral Tablet 100 MG (Milligram), Give one tablet by Gastrostomy/G-Tube two times a day at 5:00 AM and 6:00 PM related to Encephalopathy. It is not documented that R4 received the medication on 12/12/25 at 6:00 PM, 12/13 at 5:00 AM, 12/14 at 6:00 PM, and 12/20/25 at 6:00 PM. This same MAR documents an order for Keppra Oral Tablet 750 MG Give two tablets by G-Tube every 12 hours at 8:00 AM and 8:00 PM related to Intracranial Injury. It is not documented that R4 received the medication on 12/9/25 at 8:00 PM, 12/10 at 8:00 PM, 12/11 at 8:00 AM and 8:00 PM, 12/13 at 8:00 PM, and 12/14/25 at 8:00 AM and 8:00 PM. R4's Order for Hydrochlorothiazide 25 MG, Give one tablet by G-Tube one time a day at 5:00 AM related to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dilated Cardiomyopathy. It is not documented that R4 received the medication on 12/11/25, 12/13, 12/15, 12/17, 12/19, and 12/20/25. On 2/10/26 at 11:55 AM, V3/Minimum Data Set/MDS Coordinator verified that R4 did not get her Vimpat, Keppra, and Hydrochlorothiazide as ordered and V3 does not know why.2. R6's computerized Medical Record documents that R6 is a [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Diffuse Traumatic Brain Injury, Tracheostomy Status, Essential (Primary) Hypertension, and Acute Respiratory Failure.R6's Care Plan documents I am on anticoagulant therapy for clot prevention. Interventions include Administer Anticoagulant medications as ordered by physician. R6's MAR dated January 2026 documents Enoxaparin Sodium Injection Solution Prefilled Syringe 30 MG/0.3 ML (milliliter) Inject one dose subcutaneously two times a day at 5:00 AM and 8:00 PM related to Nontraumatic Intracerebral Hemorrhage in Brain Stem. Start Date 1/11/26 at 5:00 AM and discontinued 1/20/26 at 8:52 PM. This same record documents that R6 did not get the medication on 1/14/26 at 8:00 PM, 1/15 at 5:00 AM or 8:00 PM, 1/16 at 5:00 AM, 1/19 at 8:00 PM, and 1/20/26 at 5:00 AM or 8:00 PM.On 1/29/26 at 1:04 PM, V30/Facility Nurse Practitioner stated she has heard there are problems with the facility not having the medications available for the residents. When a medication is ordered V30 expects that it will be given. V30 also stated that anytime medication is not given as ordered it is a problem. If the resident is not getting a medication like Lovenox (Enoxaparin) or Keppra that could result in a serious issue.On 2/10/26 at 11:55 AM, V3/Minimum Data Set Coordinator verified that R6 did not get his Enoxaparin as ordered. V3 also stated (R6) absolutely should have been getting what the doctor ordered. I don't know why (R6) didn't get it.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on Interview and Record Review, the facility failed to ensure physician ordered laboratory (lab) monitoring was completed and processed for one of three residents (R9) reviewed for laboratory monitoring in the sample of 16.Findings include:The facility's Facility Assessment tool, dated 11/1/25, documents the facility will employ or contract hire staff to provide competent support and care for their resident population on a daily basis and during emergencies to provide clinical laboratory services and diagnostic x-ray services.R9's Physician Order Summary (POS), dated 11/20/25-2/10/26, documents R9 was ordered the following labs on 12/23/25; CBC (Complete Blood Count) one time related to pressure ulcer of sacral region, CRP (C-reactive Protein) one time related to pressure ulcer of sacral region, Hemoglobin A1C one time for diabetes, Prealbumin one time related to pressure ulcer of sacral region stage four, and Sedimentation Rate one time related to pressure ulcer of sacral region. This same summary documents R9 was ordered the following labs on 12/30/25 and 1/13/26; CBC one time every Wednesday for Tracheostomy/risk of pneumonia, and CMP (Comprehensive Metabolic Panel) one time every Wednesday for enteral feedings. This same summary documents R9 was ordered the following labs on 1/17/26; CBC, BMP (Basic Metabolic Panel) one time only for g-tube (Gastrostomy tube) leakage for one day.R9's progress note, dated 12/29/25 at 1:37 PM and completed by V30 (Facility Nurse Practitioner), documents CMP last checked on 12/22/2025 while hospitalized , within normal ranges except for elevated glucose and creatinine slightly low. CBC on 12/22/2025 with Hgb (hemoglobin) 9.9/Hct (hematocrit) 33.0, otherwise within normal limits (WNL). Check an A1C (hemoglobin A1C) with next lab draw.R9's progress note, dated 1/16/26 at 5:41 PM and completed by V30, documents Recent labs: No recent A1C available; last BMP/CBC 12/22/2025, showed elevated glucose, Hgb 9.9, otherwise WNL. Check A1C with next lab draw, ordered 1/14, not drawn, follow up on this and reorder. Weekly CBC, CMP, ordered for 1/14, not drawn, follow up on this and reorder.R9's electronic medical record does not contain documentation of any laboratory results being completed or received while R9 was in the facility (11/20/25-12/9/25 and 12/23/25-1/17/26).On 1/30/26 at 1:22 PM, V4 (Assistant Director of Nursing) confirmed R9 does not have any results for a CBC or BMP that were ordered on 1/17/26 when R9's feeding tube was leaking. V4 stated (R9) does not have any lab results (throughout his stay) because none were completed at the facility, only at the hospital.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review, the facility failed to ensure a physician orbital x-ray (radiography imaging) was completed for one of three residents (R1) reviewed for x-ray imaging in the sample of 16.Findings include:The facility's Facility Assessment tool, dated 11/1/25, documents the facility will employ or contract hire staff to provide competent support and care for their resident population on a daily basis and during emergencies to provide clinical laboratory services and diagnostic x-ray services.R1's nursing progress notes, dated 12/28/25 at 12:45 PM, documents Resident had a witnessed fall 12/28/2025 at 12:00 PM. Location of Fall: hallway (R1) was wheeling himself in wheelchair and scooted himself out of chair. Resident statement (if applicable): Resident states I was trying come get help to go lay down. I hit my head.R1's nursing progress notes, dated 12/29/25 at 6:06 AM, documents Upon report this nurse and night shift nurse noticed resident had slight swelling and a bruised right eye post-fall. Night shift notified doctor (V22, Facility Medical Director) and ongoing care and monitoring at this time.R1's progress note, dated 12/31/25 at 11:22 AM and completed by V21 (Physician's Assistant), documents Reason for visit: Fall follow-up. Review of Systems: positive for headache, positive for vision changes. Plan: Orbital X-ray.R1's electronic medical record does not document that an x-ray was ever completed or any results of an orbital x-ray for R1.R1's nursing progress notes, dated 1/4/26 at 5:00 AM, documents R1 suffered a fall and was sent to the local emergency room.R1's nursing progress notes, dated 1/5/26 at 9:55 AM and completed by V4 (Assistant Director of Nursing, ADON) documents Faxed (V21) regarding orbital x-ray ordered 12/31/25. Resident had head CT (computed tomography) on 1/4/2026 (at hospital).On 2/10/26 at 1:00 PM, V4 (ADON) confirmed R1 did not receive an orbital x-ray after it was ordered on 12/31/25. V4 stated (R1) fell on [DATE] and the orbital x-ray was ordered on 12/31/25. R1 went out to the hospital on 1/4/26 and had a CT scan. It (the x-ray) was not completed for the time (R1) was here and should have been.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate administrative oversight to ensure the facility implemented policies for wound care, medication administration, treatment administration, quality assurance measures, and basic activities of daily resident care. These failures resulted in a facility-wide lack of supervision and care leading to residents experiencing worsening pressure ulcers, severe pain, a lack of resident care for gastrostomy tubes and pressure ulcer treatments with subsequent infections requiring hospitalization, untimely assistance with incontinent care and showers resulting in residents being left in soiled conditions for extended periods, missed medication administrations with significant medication errors, and not providing a functional, licensed and engaged leadership team. This negligence posed a high potential for, and resulted in, actual harm to residents, and has the potential to affect all 53 residents residing in the facility.These failures resulted in Immediate Jeopardy. The Immediate Jeopardy started on 11/7/25 when R4 was identified at high risk of developing a pressure ulcer. V1/Administrator-in-Training, V2/Corporate/Interim Director of Nursing, and V19/Administrator from sister facility were notified of the Immediate Jeopardy on 2/4/26 at 2:04 PM. While the immediacy was removed on 2/10/26 the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.Findings include:The facility's Daily Census Report, dated 1/26/26, documents 53 residents reside in the facility.The Facility Assessment, dated 11/1/25, documents in section three Facility Resources needed to provide competent support and care for our resident population on a daily basis and during emergencies include an Administrator, Assistant Administrator, Activity Director and other activity staff.The Administrator Job Description, dated 5/2/17, documents Summary: The Administrator directs the day-to-day functions of the facility in accordance with current federal and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. Essential Duties and Responsibilities: Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities in accordance with guidelines issued by the governing board. Assist department directors in the development, use, and implementation of departmental policies and procedures and professional standards of practice, ensure that all employees, residents, visitors, and the general public follow the facility's established policies and procedures, Assist in recruitment and selection of competent department directors, supervisors, facility non-licensed staff, consultants, etcetera, Assist department directors in the topic section, planning, conducting, and scheduling of in-service training classes and on-the-job training and orientation program to assure that current material and programs are continuously provided, ensure that the resident's rights to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights, including the right to wage complaints, are well established and maintained at all times, and performs other duties as assigned. Qualifications: To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements below are representative of knowledge, skill, and/or ability required. Must possess a current, unencumbered, active license to practice as a Nursing Home Administrator.The Director of Nursing Job Description, dated 5/2/17, documents Summary: The primary purpose of the Director of Nursing position is to plan, organize, develop, and direct the overall operation of our Nursing Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and the Medical director, to ensure that the highest degree of quality (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	care is maintained at all times. Essential duties and responsibilities: Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations and guidelines that govern the nursing care facilities Develop, maintain, and periodically update written policies and procedures that govern the day-today functions of the nursing service department. Make written and oral reports/recommendations to the Administrator as necessary/required, concerning the operation of the nursing service department. Develops methods for coordination of nursing services with other resident services to ensure the continuity of the residents' total regimen of care. Maintain ongoing quality of assurance program for the nursing department. Participate in the facility surveys made by authorized government agencies as necessary or as may be directed. Assist the Quality Assessment and Assurance Committee in developing and implementing appropriate plans of action to correct identified deficiencies. Assist with discharge planning and perform administrative duties such as completing medical forms, reports, evaluations, studies charting, etcetera. Monitor the facility's Quality Indicators and Quality Measures and survey reports. Assist in the developing plans of action to correct potential or identified problem areas. Assist in calculating the number of direct nursing care personnel on duty each shift. Assign a sufficient number of licensed practical and/or registered nurses for each tour of duty to ensure that quality care is maintained. Assign a sufficient number of certified nursing assistants for each tour of duty to ensure that routing nursing care is provided to meet the daily nursing care needs of each resident. Develop work assignments and schedule duty hours, and/or assist nursing supervisory staff in completing and performing such tasks. Delegate to nursing personnel the administrative authority, responsibility and accountability necessary to perform their assigned duties. Make daily rounds of the nursing service department to ensure that all nursing service personnel are performing their work assignments. Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care, and that such care is provided in accordance with the resident's wishes. Monitor medication passes and treatment schedules to ensure that medications are being administered as ordered and that treatments are provided as scheduled. Provide direct nursing care as necessary.R1, R2, R4, R5, R6, R7, and R9's medical records document multiple missed significant medications, wound treatments, gastrostomy (g-tube) cares, and scheduled showers from 11/1/25-2/9/26.R4 was admitted to the facility on [DATE] with no pressure ulcers. On 12/12/25 a stage three pressure ulcer was found on R4's coccyx. Treatment was not started for 24 hours. Sixteen treatments were not done between 12/12/25 and 1/21/26. On 1/21/26 R4 was sent to the emergency room with complaints of fever and lethargy. R4 was admitted to the hospital with diagnoses of Severe Sepsis and Stage IV Sacral Ulcer with concern for osteomyelitis. Radiology Report documents Stage IV (four) sacral ulcer with ill-defined lower sacral and coccygeal posterior cortices which suggests osteomyelitis.R9 was admitted to the facility on [DATE] with treatment orders for a stage four pressure ulcer on his sacrum. On 12/09/25, R9 had a change in condition and was sent to a local hospital and admitted for Sepsis from stage IV sacral wound with osteomyelitis. R9 returned to the facility on [DATE]. From 12/23/25 - 1/17/26, multiple wound treatments were not completed. On 1/1/26 R9's rectal tube was accidentally removed, and the facility did not replace it due to lack of supplies. R9's sacral wound was subsequently exposed to fecal matter for extended periods of time from 1/1/26 - 1/17/26. R9's Treatment Administration records dated from 11/20/25- 1/17/26 documents multiple g-tube site care treatments and residual checks were not completed for a total of 15 uncompleted g-tube site cleansing and 26 missed residual assessments. On 1/17/26 R9 had a change in condition and was sent to a local hospital and admitted for fever, abdominal pain, diarrhea, nausea (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	and vomiting, toxic appearance, and a diagnosis of sepsis from multiple suspected sources including g-tube site infection with pus leaking drainage and a stage IV sacral wound with osteomyelitis.On 1/28/26 at 11:08 AM, V4 (Assistant Director of Nursing) confirmed that residents who have or are at risk for pressure ulcers should have skin assessments performed daily by nursing and those are not being documented for R4 or R9 who both have stage four pressure ulcers and multiple comorbidities. V4 stated Wound care and skin checks and assessments should be completed by the floor nurses.On 1/29/26 at 12:50 PM, V33 (emergency room Physician) stated I saw (R9) in the hospital. He is a very sick person and it's unfortunate. When we admitted him for the second time for Sepsis (1/17) we had him in the ER for a longer period. Any tube coming out of the body has the potential to get infected. At the time of his admission, we also were concerned with his g-tube site with purulent pus like drainage which can relate to the sepsis. If you don't take care of the g-tube properly with cleansing and flushes, then you can get infection at the site. Additionally, if the feeding is going into the abdominal cavity due to becoming dislodged it also is a risk factor for that becoming infected. I believe the g-tube was removed by gastrointestinal surgeons while in the hospital.R1's (MAR) Medication Administration Record, dated 12/1/25-12/31/25, documents R1 did not receive 18 scheduled doses of physician ordered medications in December, including Eliquis (anticoagulant), Juven (nutritional wound supplement), Zonisamide (anticonvulsant), Keppra (anticonvulsant), Metoprolol (antihypertensive), Vimpat (antiepileptic) and Modafinil (stimulant). These medications were left blank or document to see nurses notes. Follow up nursing notes for the unadministered medications document on order, not available.R2's MAR, dated November 1st - 4th 2025 documents 100% (percent) of scheduled Norco (pain medication) (5-325mg) (milligrams) doses (12 out of 12) were not administered.R4's MAR dated December 2025 documents R4 missed four doses of scheduled Vimpat Oral Tablet 100 MG, seven doses of physician ordered Keppra Oral Tablet 750 MG, and six doses of physician ordered Hydrochlorothiazide 25 MG.R6's MAR dated January 11th - January 20th, 2026, documents R6 missed seven doses of Enoxaparin Sodium Injection Solution Prefilled Syringe 30 MG/0.3 ML (milliliter).On 1/29/26 at 1:04 PM, V30/Facility Nurse Practitioner stated she has heard there are problems with the facility not having the medications available for the residents. R1, R4, R5, R6, R7, and R9's medical records do not document evidence of R1, R4, R5, R6, R7, or R9 receiving a shower in the months of December 2025 and January 2026.On 1/29/26 at 1:10 PM, V2/DON (Director of Nursing) stated she could not provide evidence or documentation showing R1, R4, R5, R6, R7, or R9 received a shower in the months of December 2025 and January 2025. V2 confirmed that no one is overseeing that showers are being documented and completed as scheduled.On 1/26/26 and 1/27/26 between 9:00 AM and 3:30 PM, facility residents were not observed in activities, no announcements were made about activities, and no current activity calendar was observed around the facility or in resident rooms.On 1/28/26 R10, R11, R12, and R13 all stated the facility does not have activities every day. At this same time, R14 also confirmed there are no daily activities and stated, They do not have a fulltime Activity Director.On 1/28/26 at 11:38 AM V25/Housekeeping Supervisor stated she fills in at times to perform activities with the residents since the facility does not have an Activity Director, but it's not often. V25 verified no activities were performed with the residents on 1/26/26 and 1/27/26. V25 stated, The last two days I had to help on the floor, so I was unable to ensure activities were being done with the residents. There are no planned activities after 4:00 PM or on the weekends for the residents.On 1/28/26 at 11:45 AM, V1/Administrator in Training verified the facility does not have a current activity director, and activities are not getting one daily.On 1/26/26, the facility did have an Administrator or Director of Nursing present in the facility until after 10:30 AM (after the state agency surveyors arrived and administration was (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	notified.)Throughout the survey from 1/26/26 through 2/3/26 multiple observations were made of V1/AIT (Administrator in Training) and V2/Interim Director of Nursing's office doors closed. V2's window on the office door remained covered throughout the survey with a dark panel, giving the appearance that the office is dark when the door is closed.On 1/27/26 at 11:20 AM V1/AIT stated I do not have a temporary license yet. I am in the classes but not eligible to apply for the AIT licenses yet. I have worked here since July of 2025 in this role. (V14) is the corporate vice president of operations (VPO), and she is the administrator over this building. (V14) is not here every day.On 1/27/26 at 12:02 PM V17/Ombudsman stated the biggest complaint she has heard in resident council meetings is that the residents are not getting showers on second and third shifts. V17 also stated there have been resident complaints about management not coming out of their office or management keeping their doors closed so the residents never know who to talk with about issues or concerns. V17 stated During resident council today, the residents stated they were very bored. The facility has not been having activities going on, no calendar has been posted or passed out to the residents' rooms, and they have not been offering daily activities. Residents have told me they have to figure out their own activities to do.On 1/30/26 at 1:22 PM, V4/Assistant Director of Nursing confirmed that V1/AIT is not in the facility on this date. On 2/2/26 at 10:00 AM, Both V1/AIT and V2/Interim Director of Nursing confirmed they were not in the building on Friday (1/30/26). At this time V1 and V2 were notified of an immediate jeopardy finding for R4 and R9's pressure ulcers.On 2/2/26 at 11:00 AM V14/ Regional VPO, confirmed she is the administrator over the facility and is training V1. V14 stated I am VP of operations over eleven homes, so I travel amongst them for regional support. From entrance of this survey (1/26/26), 2/2/26 is the first time V14 was seen in the building.On 2/3/26 at 1:33 PM V2/Interim DON stated V4/LPN (Licensed Practical Nurse)/Wound Nurse/Infection Preventionist is responsible for looking at the resident's MARS and TARS (Treatment Administration Records) daily to ensure medications were being given and treatments were being provided as physician ordered. V2 stated V4 is also responsible for ensuring the wound program is implemented and followed. V2 stated, I was not aware (V4) was not monitoring the resident's MARS and TARS daily to ensure physician orders were being followed to ensure resident's received appropriate care. I should have been aware.On 2/3/26 at 2:20PM V4/LPN/Wound Nurse/Infection Preventionist stated, I was not educated on the process of the wounds at the facility. I tried to audit to see where things were at with wounds in this facility because no wound logs were left to show who even had wounds. In December 2025 when I started, (V5/Former Director of Nursing) didn't really know what to tell me to do. V2/Interim Director of Nursing just showed me on 2/2/26 how to monitor MARS and TARs. I was not delegated to monitor TARS and MARS prior to 2/2/26.On 1/27/26 at 12:47 PM V35/LPN stated In December (V1/AIT) and (V2/Interim Director of Nursing) were calling people in and stating they couldn't tell state (agency surveyors) things and couldn't chart certain things. They didn't want us to bring up any issues or let anyone know the issues. They just wanted to hide what was going on.On 2/3/26 at 12:04 AM V41/CNA stated the facility's management is not stable. They don't take care of problems or don't seem to care about the residents. Their doors are always shut. They can do better as people and better professionally. There are no scheduled activities in the evenings for the residents. V1/Administrator-in-Training and V2/Interim Director of Nursing both keep their door shut.On 2/3/26 at 12:35 PM, V43/CNA stated that she has worked on and off at the facility for 15 years but will never step a foot back in the building since they have gotten new management. The staffing is absolutely horrible. Evenings will have two to three CNAs working. There have been times when there were only one CNA and one nurse on night shift. There are no activities in the evening. Call lights are not answered timely. It can take an hour or longer. There were (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	several residents that did not get their pain medication as needed and would complain. Wound treatments were not being done daily. When we say we are short on staff management says, we need to make it work. V1/AIT and V2/Interim Director of Nursing's doors are always closed. V2/Interim Director of Nursing only comes in once a week to give write-ups. I got a write up because I was not taking my lunch. I didn't have time to take lunch because we were short staffed. Just because there may be enough CNAs in the building if they are agency they are not as efficient, and we are not able to give the residents the care they deserve. On 2/3/26 at 1:00 PM, V42/CNA stated she has worked at the facility for about six months. The facility does not have enough staff to take care of the residents. Agency is used a lot. Nurses do the best they can, but treatments do not get done as often as they should.On 1/29/26 at 12:15 PM, V22 (Facility's Medical Director) stated The continuity of care with changes in staff and management is an issue. My communication with (V1, AIT) has been sporadic. When I come in the Administrator (V1, AIT) and DON (V2, Director of Nursing) should make me aware of concerns and issues that are happening in the building and then we can address those things in QA (Quality Assurance) and talk about solutions. I have not been notified that there is such an issue with missing treatments, missing medications and (resident) care concerns.The facility's records did not include Annual QAPI (Quality Assurance and Performance Improvement) training for all staff, 12 hours of mandatory in-service training for (CNAs) Certified Nursing Assistants, or quarterly Quality Assurance meetings.On 1/29/26 at 2:03 PM V2/Corporate/Interim Director of Nursing stated, I cannot provide documentation to show that we provided 12 hours of training to any CNAs in the past year.On 2/4/26 at 10:14 AM V1/AIT (Administrator-in-Training) verified that facility staff have not received the annual QAPI training.On 2/10/26 at 11:15 AM V14 stated that the facility has not had a QAA meeting since 7/2025 and prior to that she has no records to show the meetings were held. V14 stated when V1 started in July QA was addressed and meetings were to be held monthly per the facility and quarterly per the regulation requirement. V4 confirmed that she wasn't aware of the multiple failures and thought things were being managed when she was not in the building. On 2/10/26 the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:1. On 2/9/26 V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all Licensed Nurses on Physician Orders- Entering and Processing, and Documentation in the Health Record. The Physician Orders- Entering and Processing policy was included. On 2/9/26 all licensed nurses were educated on the facility's Physician Orders - Entering and Processing policy including but limited to when receiving, entering, and confirming physician or prescriber's orders the order is entered into the resident's chart under EMR (electronic medical record) by V2 (Director of Nursing) and V4 (Assistant Director of Nursing/ Wound Nurse).2. On 2/9/26 V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all Licensed Nurses on Pressure Injury and Skin Condition Assessment. The Electronic Health Record policy was included. On 2/9/26 all licensed nurses were educated on the facility's Documentation - Electronic Health Record policy including but not limited to entries made in the electronic health record shall be timely, accurate, relevant, and complete by V2 (Director of Nursing/Designee) or V1 (Administrator).3. On 2/9/26 V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all staff on Change of Condition and Physician-Family Notification. The Physician- Family Notification- Change in Condition policy was included. On 2/9/26 all licensed and certified nursing assistants were educated on the facility's Physician-Family Notification - Change in Condition policy by V2 (Director of Nursing/Designee) or V1 (Administrator).4. On 2/9/26 V2/Interim Director of Nursing and V4/Assistant Director of Nursing/Wound Nurse In-Serviced all staff on Comprehensive Care Plan/Baseline Care Plan. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	performed on one resident per week to ensure Dietary Department is providing resident with correct diet/supplements.38. From 2/6/26 to 2/9/26 (and ongoing) an audit was performed on one resident per day to ensure facility Infection Prevention Guidelines are followed when performing wound care.39. From 2/6/26 to 2/9/26 (and ongoing) an audit was performed on one new admission per day to ensure all equipment and supplies required are obtained and in the facility.40. From 2/6/26 to 2/9/26 the missed administration report and medication administration report were completed daily to ensure the resident's MAR is accurate and complete per facility policy and procedure guidelines.41. From 2/6/26 to 2/9/26 (and ongoing) a daily audit was completed to ensure resident who have ensure stoma site have a treatment order in place and TAR is signed off for completion, tube feeding orders are in place in the EHR (Electronic Health Record), residual check in on the resident's MAQR for prior to water flushes, medication administration and bolus feeding or a start of new bottle through feeding pump, and signs/symptoms of nausea, vomiting, distended abdomen, cramping, sluggish or absent bowel sounds, dry heaves/retching and cold sweats they physician has been notified and is documented in the HER. Any skin abnormalities at stoma site, the characteristics are documented and physician notified and documented by the nurse.42. From 2/6/26 to 2/9/26 (and ongoing) an audit was performed incorrectly on missed administration report and Medication Administration Reports. V14 reports they were not seeing when a medication was documented as on hold, only if a nurse didn't sign out the medication. V14 stated they are going to monitor all residents' MARS (Medication Administration Records) daily to ensure residents are not going without medication.43. From 2/6/26 to 2/9/26 (and ongoing) an audit was performed on one resident per day five days a week to ensure residents ar

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on Interview and Record Review, the facility failed to ensure quarterly Quality Assurance (QA) meetings were held with facility administration and the facility's medical director. This failure has the potential to affect all 53 residents residing in the facility.Findings include:The facility's QAPI (Quality Assurance Performance Improvement) plan, dated 1/2/26, documents The QA&A (Quality Assurance and Assessment) Committee reports to the executive leadership and Governing Body and is responsible for: Meeting, at minimum, on a quarterly basis; more frequently, if necessary. Coordinating and evaluating QAPI program activities. Developing and implementing appropriate plans of action to correct identified quality deficiencies. Regularly reviewing and analyzing data collected under the QAPI program and data resulting from drug regimen review and acting on available data to make improvements.The facility's most recent QA meeting sign in sheet documents a QA meeting was held in July 2025.On 2/10/26 at 11:15 AM, V14 (Corporate [NAME] President of Operations) stated that the facility has not had a QA meeting since 7/2025 and prior to that V14 stated she has no records to show when meetings were held. V14 stated When V1 (Administrator in Training) started in July of 2025 and V1 was informed that QA meetings were to be held monthly per the facility suggestion and quarterly per the regulation requirements. I did not know these were not being conducted.The facility's Daily Census Report, dated 1/26/26, documents 53 residents reside in the facility.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interview and record review the facility failed to ensure all staff received annual QAPI (Quality Assurance and Performance Improvement) in-service training. This failure has the potential to affect all 53 residents residing within the facility. Findings include:The facility's Daily Census Report, dated 1/26/26, documents 53 residents reside in the facility.The facility's List of Staff In-services, dated 1/6/25 through 2/3/26, does not include documentation of facility staff receiving annual QAPI training.On 2/4/26 at 10:14 AM V1/AIT (Administrator-in-Training) verified no staff has received the annual QAPI training.