STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Village Healthcare Ctr	1024 West Walnut Jacksonville, IL 62650

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to properly treat pressure sores, including following physician orders, for 1 of 4 residents (R9) reviewed for care of a pressure ulcer in the sample of 30. The findings include:1. R9's Face Sheet, dated 4/6/26, documents R9 was admitted to the facility on [DATE].R9's Care Plan, dated 3/25/26, documents R9 has alteration in skin integrity as evidence by pressure ulcer, wound healing may be hindered due to resident noncompliance with being turned every two hours, and offloading her buttocks, resident prefers to lay on her back. Interventions: Encourage/assist with turning/repositioning every two hours and PRN (as needed), keep clean and dry as possible, minimize skin exposure to moisture, provide/assist with continence care as needed, keep linens dry and wrinkle free to prevent further pressure forces, maintain head of bed at/or below 30 degrees or at lowest degree of elevation consistent with the resident's medical condition to prevent sliding and shear-related injury that may prohibit wound healing and/or cause further wound development, measure and document wound characteristics observations weekly, minimize pain by assessing and administering pain medication as ordered by physician, reduce friction and/or shearing to prevent wound from declining and further wound development.R9's Minimum Data Set (MDS), dated [DATE], documents R9 has a severe cognitive impairment and is dependent on staff for Activities of Daily Living (ADLs). R9 is frequently incontinent of both bowel and bladder. R9's Physician Order, dated 3/4/26, documents Site: Right Buttock- Cleanse, pat dry, apply hydrocolloid dressing. Special Instructions: Apply Q (every) 3 Days and PRN (as needed). Once A Day Every 3 Days; 1st Shift. This order was Discontinued on 3/11/26 when R9 was hospitalized . R9's Medication Administration Record (MAR)-Treatment Administration Record (TAR), dated 3/1/26 through 3/31/26, documents the order placed on 3/4/26 was signed off as completed on 3/4/26, then not again until 3/8/26, and then on until 3/11/26. R9 was sent to the hospital on 3/11/26 and returned to the facility on 3/16/26 with diagnosis of Pneumonia.R9's Physician Order, dated 3/17/26, documents Site: Peri area/Buttock May apply moisture barrier with each incontinent episode. Special Instructions: May keep barrier cream at bedside for CNA (Certified Nursing Assistant) to apply.R9's Physician Order, dated 3/17/26, documents Site: Bilateral Buttocks- Cleanse, pat dry, apply a dime thick layer of triad paste. Special Instructions: Apply daily and PRN. Once A Day; 1st Shift.R9's MAR-TAR, dated 4/1/26 through 4/30/26, documents Site: Bilateral Buttocks- Cleanse, pat dry, apply a dime thick layer of triad paste. Special Instructions: Apply daily and PRN. Once A Day; 1st Shift. This was signed off as completed daily from 4/1/26 through 4/14/26. On 4/7/26 at 8:55 AM, V14, Licensed Practical Nurse (LPN)/Wound Nurse, stated I work on Tuesdays through Fridays and the other days the regular nurses do the wound care. V14 was seen providing wound care to R9. A Contact Isolation sign was on the door with Personal Protectant Equipment (PPE) hanging on the door. Both V14, and V7, CNA, entered R9's room for wound care with no PPE on. R9 was rolled to her left and her incontinent brief was removed and appeared slightly wet. V14 removed R9's undated dressing to her coccyx/buttocks and stated that it was a Hydrocolloid dressing, stated their policy is to not date the dressings. V14 used Normal Saline and poured it over the wound, then used 4x4 gauze to pat dry the wound with no cleaning or wiping of the wound site. V14 then applied Triad Paste to the area and rolled R9 back to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145294	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her backside. When asked about a dressing or incontinent brief back on, V14 stated I like to let her air out. and covered R9 back up. There was no PPE worn except for gloves during wound care.On 4/15/26 at 8:35 AM, V14 stated (R9) had orders for the hydrocolloid dressing up until she was hospitalized on [DATE]. When she came back on 3/16/26, she was seen by the wound NP (Nurse Practitioner) and she placed an order to put Triad paste on instead of the dressing. That Hydrocolloid dressing that we saw on (R9) should not have been on there. I'm guessing the weekend or Monday nurse did the wrong wound care.On 4/21/26 at 10:28 AM, V30, Registered Nurse (RN)/Infection Preventionist (IP), stated If I have to do wound care, I will look in the resident's TAR for the order and what to do. If the order was changed, the old order should be marked off as discontinued in the TAR and the new order should be put on the TAR in its place.On 4/21/26 at 10:55 AM, V2, Director of Nursing (DON), stated I would expect the nurses to follow the physician's order for wound care and to discontinue any order that has changed and to enter the new order so it will be followed.The facility's Pressure Wound Treatment Policy, dated 1/2025, documents in part The purpose of this procedure is to provide guidelines for the care of existing pressure injuries and the prevention of additional pressure injuries. Pressure injury treatment requires a comprehensive approach, including: 1. Debridement. 2. Managing infections. 3. Managing systemic issues (edema, venous insufficiency, etc.). 4. Maximizing the potential for healing. 5. Pain control.

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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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on interview and record review the facility failed to obtain a urine sample timely and properly insert a catheter for 1 of 5 residents (R13) reviewed for urinary tract infections in the sample of 27. This failure resulted in the untimely collection of a urine specimen, with collection not occurring until 4 days after the order was received. During this time R13 suffered increasing symptoms with ultimately a malposition foley catheter being inserted into R13's urethra with a partially inflated balloon, despite the order given being for a straight catheter. R13 developed urosepsis and septic shock with hospital stay from [DATE]-[DATE] with ICU care for 7 days and ultimately death on [DATE] caused by sepsis and UTI.The immediate jeopardy began on [DATE] when R13 was transferred to local hospital due to change in condition in which the facility had not obtained a urine sample. R13's labs at the local hospital indicated R13 had a UTI. The facility inserted a foley catheter improperly causing obstruction, resulting in R13 being transferred to another hospital to ICU for septic shock. The Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level 2 because additional time is needed to evaluate the implementation and effectiveness of the in-service training. B. Based on interview and record review the facility failed to follow infection control guidelines while cleansing a catheter, failed to provide an ordered cream when cleansing a catheter, failed to provide a securing device for a catheter, failed to provide catheter care in a comfortable manner, and failed to complete incontinence care for five residents (R14, R21, R12, R9 and R18.) Findings include: 1.R13's undated face sheet documents R13 was admitted to the facility on [DATE] with metabolic encephalopathy, dementia and no history of Urinary Tract Infections (UTI's). R13's Minimum Data Set (MDS) dated [DATE] does not document an interview of mental status. R13's MDS does document that R13 is dependent on staff for toileting hygiene. R13's MDS documents R13 is always continent of urine. R13's care plan dated [DATE] documents bladder incontinence related to weakness, encephalopathy, dementia, history of prostate cancer s/p prostatectomy. R13's care plan documents the following interventions: 6/6 report any sign of skin breakdown (sore, tenderness or red broken areas) 6/6 report signs of UTI (acute confusion, urgency, frequently bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain R13's progress notes dated [DATE] R13 was noted with agitation and aggression and order for urine C/S obtained. Facility staff did not obtain a urine sample from [DATE]-[DATE]. R13's hospital ED report date [DATE] documents history decreased loc, and urine output x 2 days. Nausea and vomiting today. Order Hx. Hematuria history of Surgery: prostatectomy prostate cancer. Report documents the urinary bladder is decompressed. Foley catheter is identified. Non-dependent gas in the urinary bladder, likely related to catheterization. R13's ED labs dated [DATE] at 10:15 documents urine cloudy, mucous present, trace of bacteria, Red Blood cells 11-25. R13's hospital report dated [DATE], generated [DATE], documents encounter [DATE] documents R13 seen and examined at bedside. Transferred out of ICU today after resolution of septic shock. Currently awake and confused but calm. No acute distress. Foley draining clear amber urine. The (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	report documents Assessment/Plan Septic shock secondary to foley-associated UTI with proteus bacteremia (resolved); required ICU admission and vasopressor support, now off Levophed;hemodynamically stable, blood cultures growing proteus, afebrile, improving leukocytosis, continue with IV ceftriaxone monitor WBC, vitals, fever curve, urology following, transition of oral antibiotics when appropriate 2) Urosepsis/complicated Uti: in setting of mispositioned foley catheter, associated hematuria and obstruction Plan: maintain foley care, ensure proper positioning, strict I/o's 4) Mild hydronephrosis/possible polynephritis; seen on AT a/p, likely secondary to obstruction/infection plan: continue antibiotics, monitor renal function, urology follow up 5) traumatic hematuria secondary to foley malposition (improved); balloon partially inflated in urethra on admission, hematuria resolving Plan continue foley monitoring, irrigation prn, notify urology if recurrence 10) History of prostate cancer s/p prostatectomy 7/2024 with possible metastatic lymphadenopathy; cat showing retroperitoneal lymph nodes On [DATE] V1, Administrator inserted a foley catheter to obtain a urine sample. R13's order was for a straight catheterization instead of a foley catheter and V1 left the foley to urinary drainage bag due to inability to obtain specimen. R13 was transferred to the local hospital due to change in condition of not opening eyes, not eating/drinking and blood-tinged urine. R13's hospital record documented R13 was found to have the foley catheter inserted incorrectly and obstructed in the urethra with balloon partially inflated causing hematuria obstruction/infection. R13's record documents R13 was in the ICU for 7 days and received IV antibiotics for Septic Shock secondary to foley associated UTI, Urosepsis in setting of mispositioned foley catheter, likely secondary to obstruction/infection. R13 remained in the hospital until [DATE] when R13 ultimately expired. R13's death certificate dated [DATE] document cause of death: sepsis, UTI V35, physician stated R13 has no history of UTIs and that he agrees with the death certificate and that Urosepsis could cause death. R13's progress notes dated [DATE] at 7:23AM documents Urine collected per sterile technique for UA C & S at 0650 and transported to JMH Lab at this time. On [DATE] at 1:39PM V35, physician per telephone interview stated he could agree with Urosepsis as cause of death. V35 stated R13 does have a standing order in place for straight catheterization a resident for urine specimen. V35 stated when catheterizing a resident for a specimen you should get enough urine for a specimen if the catheter is in the bladder. V35 stated R13 did not have frequent UTIS On [DATE] at 9:27 am V1, Administrator stated a catheter was inserted to obtain a urine specimen on R13. V1 stated R13 had a change in condition and was sent out to the hospital with foley before results came back. V1 stated R13 's wife called the next day and said R13's foley was not inserted correctly. V1 stated it was inserted correctly as she inserted the foley. V1 stated the wife had been notified of foley being inserted. V1 stated R13 was sent to the hospital and did not return. V1 stated R13 died a few weeks later. On [DATE] 5:00PM V41, Medical Director of the [NAME] hospital stated R13 had decreased urinary output and the cat scan showed left hydronephrosis which shows R13 has a structural problem which indicated R13 more susceptible to UTI. V41 stated delay in treatment could be why R13 had to be sent to Emergency Department. V41 stated R13 had leukocytosis at outlying hospital and blood cultures showed proteus in R13's blood. V41 stated R13 was sent to the [NAME] hospital admitted to ICU due (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to septic shock. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy: Starting on [DATE], All nurses including nurses on leave or on vacation were in-serviced on the following: Insertion of foley catheter and care on male and female residents; conducted by RN Regional Nurse Consultant with completion date of [DATE]. Assessment of residents who have a catheter for signs and symptoms of urinary tract infection. Inservice Completion date of [DATE]. Nurses will complete post tests to gauge understanding of in-services. Post tests completed per [NAME] RN/DON with completion date of [DATE]. Starting on [DATE], all CNA staff, including CNAs on leave or on vacation, were in-serviced on signs and symptoms of urinary tract infection and notify nurses if noted. Inservice conducted by RN/DON with completion date of [DATE]. CNAs will complete post tests to gauge understanding of in-service. Psot test completed by [NAME] with completion date [DATE]. Starting on [DATE], All residents with an indwelling catheter device were assessed for a urinary tract infection. Any resident with signs and symptoms of urinary tract infection will be monitored, and provider will be notified. Completed by LPN with completion date [DATE] All care plans for residents with Catheters have been reviewed and updated with completion date of [DATE]. A QA study will be performed randomly twice weekly for three months to staff knowledge on catheter insertion and care by the Director of Nursing/Designee beginning [DATE]. A QA study will be performed randomly twice weekly for three months to ensure residents with catheters are assessed for urinary tract infections by Director of Nursing/Designee [DATE]. QA audits will be presented and reviewed at the facility monthly QA meetings for three months to ensure maintained compliance, and on an as needed basis thereafter as deemed necessary by the QA committee. 2. On [DATE] at 10:14AM during catheter care V25 CNA entered room with enhanced barrier sign posted outside door did not put on a gown or sanitize hands prior to entering room. With R14 on his back V25, CNA with basin water and complete bath and body wash V25 applied soap on wet cloth from basin. V25 cleansed left and right side of groin with soaped cloth, cleansed penis and catheter tubing. At no time during catheter care did V25 rinse or dry R14. R14' s care plan dated [DATE] documents R14 has an indwelling foley catheter. R14's care plan documents intervention dated [DATE]; provide catheter care every shift as needed. R14's undated face sheet documents a diagnosis in part of obstructive and reflux uropathy. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. R21's Face Sheet, dated [DATE], documents R21 was originally admitted to the facility on [DATE] with diagnosis of Chronic Kidney Disease-stage 3, Acute Kidney Failure, Cystitis, Tubulo-Interstitial Nephritis, Anemia, Hypothyroidism, Type 2 Diabetes Mellitus, and Ogilvie syndrome. R21's Care Plan, dated [DATE], documents R21 requires a suprapubic catheter related to urinary retention. Interventions: Enhanced barrier precautions (EBP), keep catheter system a closed system as much as possible, document urinary output every shift, record the amount, type, color, odor, observe for leakage. R21's Minimum Data Set (MDS), dated [DATE], documents R21 is cognitively intact and is dependent on staff for toileting. R21 has urinary catheter in place and is frequently incontinent of bowel. On [DATE] at 11:22 AM, V9, Certified Nursing Assistant (CNA), entered R21's room to provide peri-care and catheter care on R21. There was an EBP sign with Personal Protectant Equipment (PPE) hanging on door and V9 failed to put on PPE prior to providing resident care. V9 donned gloves, obtained a wet washcloth from a water basin, wiped around R21's suprapubic catheter site, then used the same soiled gloves to obtain another wet washcloth and cleaned R21's right and left groins. V9 obtained another wet washcloth from the water still using the same soiled gloves and wiped R21's penis and scrotum. V9 obtained another wet washcloth and rinsed all areas, then obtained a dry towel and dried all areas cleaned. V9 then covered up R21 all while using the same soiled gloves. V9 failed to put ordered cream on V21 after peri-care and failed to put a secure device in place for catheter with catheter hanging freely from opening site. R21's Physician Order (PO), dated [DATE], documents Catheter: Supra Pubic Catheter continuously for retention. R21's PO, dated [DATE], documents Enhanced Barrier Precautions. R21's PO, dated [DATE], documents Catheter: Change securement device weekly Once a Day on Sun; 2nd Shift. R21's PO, dated [DATE], documents Catheter: Clean Supra Pubic catheter site every shift. Every Shift: 1st Shift, 2nd Shift. R21's PO, dated [DATE], documents Catheter: Clean Supra Pubic catheter site PRN. As Needed. R21's PO, dated [DATE], documents May keep moisture barrier cream at bedside. R21's PO, dated [DATE], documents Site: Peri area/Buttock May apply moisture barrier with each incontinent episode. Special Instructions: May keep barrier cream at bedside for CNA to apply. R21's PO, dated [DATE], documents Site: Suprapubic Catheter- cleanse with soap and water, pat dry, apply nystatin powder and drain sponge. Secure with paper tape. R21's Hospital Record, dated [DATE], documents in part Patient presented to the ER (Emergency Room) with decreased urination. The patient has a chronic suprapubic catheter. He reports that he has been weak but denied any nausea, vomiting, fever chills. He denies any chest pain, shortness of breath or difficulty breathing. In the ER, Hemoglobin 7.4, WBC (white blood cell) 3.79, Potassium 5.6, BUN (Blood Urea Nitrogen) 44, Creatinine 2.88, UA (urinalysis) consistent with UTI (urinary tract (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	infection). bladder wall is mildly thickened. There is a suprapubic catheter again demonstrated with some inflammatory changes present along the course of the suprapubic catheter. The patient was treated with IV (intravenous) antibiotics for his urinary tract infection. R21's Nursing Note, dated [DATE] at 10:06 PM, documents in part Supra pubic catheter draining clear dark yellow urine w/o difficulty. Continues on an antibiotic for UTI. No adverse effects noted. Extensive staff assistance provided for transfers, mobility, eating, and toileting. 4. R12's Face Sheet, dated [DATE], documents R12 was originally admitted to the facility on [DATE]. R12's Care Plan, dated [DATE], documents R12 has Urinary Incontinence related to impaired mobility, pain, diabetes mellitus (DM). Interventions: Apply moisture barrier to skin, ensure adequate bowel elimination, keep call light in reach, provide assistance for toileting, provide incontinence care after each incontinent episode. R12's MDS, dated [DATE], documents R12 has moderate cognitive impairment and is dependent on staff for toileting, bathing, dressing, substantial/moderate assistance for transfers. R12 is frequently incontinent of both bowel and bladder. R12's PO, dated [DATE], documents Enhanced Barrier Precautions - Isolation. R12's PO, dated [DATE], documents Site: Peri area/Buttock May apply moisture barrier with each incontinent episode. May keep barrier cream at bedside for CNA (Certified Nursing Assistant) to apply. On [DATE] at 10:19 AM, R12 was assisted to the toilet by V26, CNA, and V28, CNA. R12 was assisted to stand and pivoted to the toilet and lowered. R12 stated she was done so V26 used a handful of wipes and reached between R12's legs and wiped once from front to back. V26 got another handful of wipes and again reached between R12's legs and wiped once again from front to back. R12 asked them to be careful because she is very tender, then complained that it hurt upon wiping. R12's buttocks and anal area appear reddened and slightly excoriated. V28 pulled up R12's same incontinence brief and pants and assisted her to sit back in her wheelchair. There was no cleaning of R12's vagina, front side/peri-area, or a clean incontinent brief applied. There was no barrier cream applied to R12's sore buttocks/anal area and no hand hygiene and glove changes when going from soiled areas to clean areas. 5. R9's Face Sheet, dated [DATE], documents R9 was admitted to the facility on [DATE]. R9's Care Plan, dated [DATE], documents R9 has alteration in skin integrity. Interventions: Encourage/assist with turning/repositioning every 2 hours and PRN, keep clean and dry as possible, minimize skin exposure to moisture, provide/assist with continence care as needed, utilize incontinence briefs to prevent trapping moisture against the skin, utilize incontinent skin barriers such as creams, ointment, pastes, and film-forming skin protectants as needed to protect and prevent further skin breakdown, keep linens dry and wrinkle free to prevent further pressure forces. R9's MDS, dated [DATE], documents R9 has severe cognitive impairment and is dependent on staff for ADLs. R9 is frequently incontinent of both bowel and bladder. R9's PO, dated [DATE], documents Site: Peri area/Buttock May apply moisture barrier with each (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy Perineal Care dated, revised [DATE], documents the purpose is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. The policy documents the following equipment wash basin, towels, washcloth, soap or cleansing agent. The policy documents wash and dry hands thoroughly and apply gloves, fill the wash basin one- half full of warm water Place the wash basing on the bedside stand within easy reach The policy documents for a female resident: wet washcloth and apply soap or skin cleansing agent, wash perineal area, wiping from front to back, separate labia and wash area downward from to the back, gently rinse and dry the area the area., continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side and using downward strokes, rinse perineum thoroughly in same direction, gently dry perineum instruct, or assist resident the resident to turn on side with top leg slightly bent if able rinse wash cloth and apply soap or skin cleansing agent. Wash rectal area thoroughly, wiping from base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia, rinse thoroughly using the same technique as described above. Dry area thoroughly. The Facility's Suprapubic Catheter Care Policy, dated 2005, documents in part The purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract.

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NAME OF PROVIDER OR SUPPLIER Prairie Village Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1024 West Walnut Jacksonville, IL 62650	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on interview and record review the facility failed to replace a broken c-pap mask timely for 1 of 3 residents (R1) reviewed for respiratory therapy in the sample of 30. Findings include:1 R1's progress notes dated 2/2/2026 at 2;57PM documents Resident's c-pap mask is broke, and medical supply company is bringing a new one tomorrow 2/3. Oxygen on at 3L (liters)/NC. (nasal cannula)R1's progress notes dated 2/1 2026 at 11:37PM documents Resident complained of Shortness Of Breath (SOB) at bedtime (hs). Nebulization treatment administered per order. Post-treatment SpO2 improved to 92%. Noted mask is broken and requires replacement; Resident continues to be monitored for further respiratory distress, on continuous O2 therapy via at 4L via nasal cannulaR1's undated face sheet documents a diagnosis in part of Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory failure wit hypoxia, Dependent on supplemental oxygen, and obstructive sleep apnea. R1's physician orders dated 1/31/2026 documents 02 (oxygen) at 3L (liters) per nasal cannula if refuses c-pap or if not available for any other reason. R1's PO dated 10/24/2025 documents c-pap-bi-ap on nap time and at night to maintain oxygen saturation greater than 92%. On 4/13/2026 at 10:40AM V2, Director of Nursing (DON) stated if something is wrong with a mask, the medical supply provider is notified and mask is sent out. V2 stated sometimes same day or next day. V2 stated If a resident has a history of respiratory failure and is having SOB and no mask available, the physician should be notified and see what he recommends. V2 stated R1 should have a mask as ordered On 4/13/3036 11:29AM V33, medical supply provider stated a c-pap mask was sent to the facility on 2/3/2026. V33 stated they did not have a specific name but only request for mask that had been received from the facility.The facility policy CPAP/BIPAP support date, revised April 2007 documents the purpose is to provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen, to improve arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive obstructive lung disease and to promote comfort and safety. CPAP (continuous positive airway pressure) can be used in conjunction with ventilation to improve oxygenation. CPAP may be appropriate for improving arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. The policy documents the mask should fit firmly but does not need to be airtight, the mask should fit firmly but does not need to be airtight.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, observation, and record review, the facility failed to administer an antibiotic to a resident with a diagnosis of Urinary Tract Infection (UTI) and failed to follow physician orders to administer medications for 2 of 5 residents (R21, R22) reviewed for medication administration in the sample of 30.The findings include:1. R21's Face Sheet, dated 4/7/26, documents R21 was originally admitted to the facility on [DATE].R21's Care Plan, dated 4/6/26, documents R21 requires a suprapubic catheter related to urinary retention. Interventions: Enhanced barrier precautions, keep catheter system a closed system as much as possible, document urinary output every shift, record the amount, type, color, odor, observe for leakage. R21's Minimum Data Set (MDS), dated [DATE], documents R21 is cognitively intact and is dependent on staff for toileting. R21 has urinary catheter in place and is frequently incontinent of bowel.R21's Hospital Record, dated 4/10/26, documents in part Patient presented to the ER (Emergency Room) with decreased urination. The patient has a chronic suprapubic catheter. He reports that he has been weak but denied any nausea, vomiting, fever chills. He denies any chest pain, shortness of breath or difficulty breathing. In the ER, Hemoglobin 7.4, WBC (white blood cell) 3.79, Potassium 5.6, BUN (Blood Urea Nitrogen) 44, Creatinine 2.88, UA (urinalysis) consistent with UTI (urinary tract infection). bladder wall is mildly thickened. There is a suprapubic catheter again demonstrated with some inflammatory changes present along the course of the suprapubic catheter. The patient was treated with IV (intravenous) antibiotics for his urinary tract infection.R21's Physician Order, dated 4/10/26, documents Cefdinir 300 MG (milligram) Every 12 hours: 7:00 PM and 7:00 AM X 10 days Dx (diagnosis) UTI (urinary tract infection). This order was discontinued on 4/13/26. R21's Nursing Note, dated 4/13/26, documents Cefdinir allergy discussed with Doctor, may continue to give medication beginning today. POA (power of attorney) aware.R21's Physician Order, dated 4/13/26, documents Cefdinir 300 MG Twice a Day, Every Day, 6:00 AM and 6:00 PM, X 10 days Dx UTI.R21's Medication Administration Record (MAR), dated 4/1/26 through 4/20/26, documents R21 had Cefdinir 300 MG every 12 hours ordered on 4/10/26. R21 only received one dose of Cefdinir from 4/10/26 until 4/13/26.R21 was sent to the hospital on 4/6/26 and returned on 4/10/26 with the hospital discharge order for Cefdinir 300 MG every 12 hours. This was started on 4/11/26 on the day shift, then was not given until 4/13/26 when the order changed on 4/13/26.On 4/16/26 at 9:02 AM, V2, Director of Nursing (DON), stated The night shift nurse gave (R21) his antibiotic from the (medication dispensing machine) at 6:00 AM on 4/11/26, then the same nurse worked the night shift on 4/11/26 and the antibiotic was not given at 7:00 PM or the 6:00 AM dose on 4/12/26. The pharmacy did not send the antibiotic due to an allergy alert for Cefdinir. When asked why the doses were not given if they were available in the (medication dispensing machine) and V2 stated I don't have an answer for that. When asked if the antibiotic should have been given from the machine, V2 stated Yes, they should have given the medication from the machine. When asked if the pharmacy was not sending the medication due to an allergy alert, why did it take until 4/13/26 for the nurses to ask the physician about it, V2 stated I don't have an answer for that.R21's Physician Order, dated 12/20/25, documents Folic Acid 1 MG Once a day, every day at 6:00 AM. This order was discontinued on 4/9/26.R21's Physician Order, dated 4/10/26, documents Folic Acid 1 MG Once a day, every day at 6:00 AM.On 4/7/26 at 11:30 AM, While in the room observing care on R21, there was a light yellowish pill lying on the side table along with two medicine cups of creams: one with a mixture of creams. V11, Licensed Practical Nurse (LPN), was notified and stated I didn't give (R21) any medications this morning because he gets them at 6:00 AM. Those creams look like they mixed an antifungal cream with something else, and I believe that was supposed to be put on (R21's) bottom. V11 opened medication cart and reviewed each of R21's medications and stated, It looks like the nurse gave the stock Folic Acid which was only 400 MCG (micrograms) instead of his Folic Acid 1000 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MCG that he has on a card that he should have gotten.On 4/7/26 at 11:35 AM, V2, DON, was notified and stated, That should not happen, and it will not happen again. 2. R22's Face Sheet, dated 4/7/26, documents R22 was originally admitted to the facility on [DATE] with diagnosis of Chronic Kidney Disease-stage 4, Dependence on renal dialysis, Congestive Heart Failure (CHF), Type 2 Diabetes Mellitus, Seizures, Benign neoplasm of colon, Tubulovillous Adenoma of colon, Anemia, Atherosclerotic heart disease, Atrial Fibrillation, Peripheral Vascular Disease, Anxiety Disorders, Major Depressive Disorder, Osteoarthritis, Atrioventricular block first degree.R22's Care Plan, dated 3/18/26, documents R22 receives dialysis on Monday, Wednesday, and Friday related to Chronic Kidney Disease-stage 4 (severe). R22 is at risk for side effects related to the use of Levetiracetam (anticonvulsant). Interventions: Gradually discontinue levetiracetam to reduce the risk of withdrawal symptoms such as increased seizure frequency and status, Levetiracetam may cause nonpsychotic symptoms such as aggression, agitation, anger, nervousness, etc. R22's Physician Order, dated 3/1/25, documents Levetiracetam 500 MG; Special Instructions: Once a Day on Sunday, Tuesday, Thursday, Saturday; 08:00 AM.R22's Physician Order, dated 3/1/26, documents Levetiracetam tablet; 500 MG; amt (amount): 2 tabs; oral. Special Instructions: Once a Day on Monday, Wednesday, Friday; 08:00 AM.On 4/7/26 at 9:30 AM, V11, LPN, was seen passing medications to R22. V11 stated (R22) is supposed to get Levetiracetam (Keppra) 500 MG today, but we are out of it. While giving R22 her medications, V11 told R22 that she will have to wait until tomorrow (4/8/26) to get her Levetiracetam because they were out of it, and she won't get it from the pharmacy until tomorrow.On 4/20/26 at 3:15 PM, V3, LPN, stated We have Keppra in the (medication dispensing machine). If (R22) was out of it, the nurse should have gotten it out of the (medication dispensing machine) and given it to R22.On 4/20/26 at 3:20 PM, V2 stated The nurse should have gotten (R22's) Keppra from the machine so she did not miss a dose. The nurse should have documented something about it and should have notified the physician.On 4/20/26 at 10:30 AM, V30, Registered Nurse (RN)/Infection Preventionist (IP), stated If I find any resident that is missing a medication, I would first check to see if we have it in the (medication dispensing machine), and if not, I will document that it was not given and why, then I would check the order and call the pharmacy. Our pharmacy is very good at sending us medications quickly when called.On 4/21/26 at 10:55 AM, V2, DON, stated I would expect the nurses to call the pharmacy and/or backup pharmacy for a missing medication, then notify the physician, and put in a progress note regarding the missing medication. I would expect the nurses to try to get the medication out of the Pyxis if available to avoid the resident missing a dose.The facility's Medication Administration Policy, dated 10/24/25, documents in part 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 medication management system in the facility. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. 4) Five Rights: Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. a. Check #1: Select the Medication - label, container and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the 5 Rights. b. Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights. 5) Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. If the label and MAR are different and the container is not flagged, indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. 11. If a (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit. B. Administration: 2) Medications are administered in accordance with written orders of the prescriber. 4) When medications are administered by mobile cart taken to the resident's location (room, dining area, etc.) medications are administered at the time they are prepared. Medications are not pre-poured. 18) The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to don Personal Protective Equipment (PPE) for residents on Enhanced Barrier Precaution (EBP) and Contact Isolation, and to do hand hygiene and glove changes when necessary for 4 of 4 residents (R9, R12, R15, R21) reviewed for infection control in the sample of 30.The findings include: 1. R9's Face Sheet, dated 4/6/26, documents R9 was admitted to the facility on [DATE].R9's Physician Order, dated 4/17/26, documents Strict Isolation Type: Contact: Wound- Abdominal Wall Cellulitis, follow Contact Isolation.On 4/7/26 at 8:55 AM, a Contact Isolation sign was seen on R9's door with Personal Protectant Equipment (PPE) hanging on the door. Both V14, Licensed Practical Nurse (LPN)/Wound Nurse, and V7, Certified Nursing Assistant (CNA), entered R9's room for wound care with no PPE on. Before, during, or after wound care, there was no PPE worn except for gloves.2. R12's Face Sheet, dated 4/6/26, documents R12 was originally admitted to the facility on [DATE]. R12's Physician Order, dated 2/3/26, documents Enhanced Barrier Precautions (EBP) - Isolation.On 4/9/26 at 10:19 AM, a EBP sign and PPE were seen hanging on R12's door. V26, CNA, and V28, CNA were seen assisting R12 to use the restroom and to provide peri-care. Neither CNA donned appropriate PPE prior to assisting R12 with toileting.3. R15's Face Sheet, dated 4/15/26, documents R15 was admitted to the facility on [DATE].R15's Care Plan, dated 2/18/25, documents R15 requires Enhanced Barrier Precautions (EBP) due to indwelling medical device. Interventions: Follow facility's Infection Control and Enhanced Barrier Precautions policies/procedures when cleaning/disinfecting room, handling soiled and/or contaminated linen, disinfecting, gown and glove use when performing high-contact resident contact activity, have adequate PPE available, practice good hand washing, teach resident/caregiver the chain of infection/methods of transmission, use principles of infection control and enhanced barrier precautions.R15's Physician Order, dated 2/9/26, documents Enhanced Barrier Precautions.On 4/7/26 at 9:25 AM, An EBP sign was seen on R15's door with PPE hanging on the door. V11, Licensed Practical Nurse (LPN), was seen going into R15's room to fix R15's gastric tube (g-tube). V11 did not don PPE while working with the g-tube as the g-tube had become disconnected and R15 was holding it in her hands. V11 donned gloves only, then put the g-tube back together. V11 stated It keeps coming apart, so I figured maybe I'll use an alcohol pad to clean it real good would help it stay connected. V11 did not don PPE during process and doffed her gloves and exited the room without hand hygiene.4. R21's Face Sheet, dated 4/7/26, documents R21 was originally admitted to the facility on [DATE].R21's Physician Order, dated 2/3/26, documents Enhanced Barrier Precautions.On 4/7/26 at 11:22 AM, V9, CNA, entered to provide peri-care and catheter care to R21. There was an EBP sign with PPE hanging on door. V9 failed to don PPE when providing care to R21. V9 used one pair of gloves while performing peri-care and catheter care on R21, including getting wet washcloths from a water basin using soiled gloves. V9 also used same soiled gloves to dry all areas cleaned and then cover R21 up with his sheet/blanket. V9 failed to change gloves and do hand hygiene when going from dirty areas to clean areas of R21, including catheter care.On 4/16/26 at 9:03 AM, V39, CNA, stated I check on my residents about every 15 minutes and I am always walking up and down the hall checking on the residents. If a resident is on EBP, I put on the PPE before I take care of that resident. On 4/16/26 at 9:07 AM, V5, CNA, stated I check on my residents all the time. When asked about a EBP sign on the door, V5 stated I don't remember what that is. V5 stated If someone is on Contact isolation, I would wear a gown, gloves, and a mask.On 4/21/26 at 10:55 AM, V2, DON, stated I would expect all staff to don appropriate PPE when a resident is on EBP or any type of isolation. I would expect all staff to perform hand hygiene before, during glove changes, and after care. I would expect all staff to change gloves when soiled and when going from soiled area to a clean area.The Facility's Enhanced Barrier Precaution Policy, dated 3/21/25, documents in part It is the practice of this facility to implement enhanced barrier precautions for the prevention of transmission (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of multidrug-resistant organisms. Enhanced Barrier Precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with MDRO (Multidrug Resistant Organisms) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).The Facility's Hand-Washing/Hand Hygiene Policy dated 10/2025, documents in part It is the policy of the facility to assure staff practice recognized hand-washing/hand hygiene procedures as a primary means to prevent the spread of infections among residents, personnel, and visitors. Alcohol based hand rubs (ABHR) can be used for hand hygiene when hands are not visibly soiled or contaminated with blood or bodily fluids. 4. When hands are not visibly soiled, employees may use an alcohol-based hand rub (foam, gel, liquid) containing at least 60% alcohol in all of the following situations: a) before direct contact with residents; b) after direct contact with a resident but prior to direct contact with another resident; c) before donning gloves; d) before performing any non-surgical invasive procedures; f) before handling clean or soiled dressing, gauze pads, etc. g) before moving from a contaminated body site to a clean body site during resident care; h) before and after putting on and upon removal of PPE, including gloves; i) after contact with a resident's intact skin; j) after handling used dressings, potentially contaminated equipment, etc. k) after contact with objects such as medical devices or equipment in the immediate vicinity of a resident that may be potentially contaminated; l) after contact with potentially infectious material; m) after removing gloves. 6. The use of gloves does not replace compliance with hand-washing/hand hygiene procedures.The Facility's Isolation - Categories of Transmission-Based Precautions Policy, dated 3/3/25, documents in part Appropriate precautions shall be used either at all times (Standard Precautions) or for individuals who are documented or suspected to have infections or communicable diseases that can be transmitted to others (Transmission-Based Precautions). Contact Precautions: In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. C. Gloves and Handwashing: 1) In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room. 2) While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). 3) Remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent (handwashing is required with C.diff/ Clostridioides difficile). 4) After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room.The Facility's Infection Control Policy, dated 10/2025, documents in part It is the policy of this facility to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent or eliminate when possible, the development and transmission of disease and infection.