STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145338	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Rehab and Nursing Center	512 East Ogden Avenue Westmont, IL 60559

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to supply clean linens in sufficient quantities for resident care needs. This applies to all 98 residents residing in the facility. The findings include: Facility Midnight Census Report, dated 1/30/25, shows the facility census was 98 residents. On 12/30/25 at 2:23 PM on the first floor, the linen carts had only one washcloth and no towels available for resident care. The one washcloth had the seam missing on two sides of the cloth and the edges were frayed. On 12/30/25 at 2:39 PM on the second floor, one linen cart had no washcloths, no bath towels, three bed sheets, 1 pillowcase and 1 blanket. At 2:42 PM on the first floor, a second linen cart had only 1 washcloth, 3 bed sheets, 3 blankets, and 3 gowns on the cart. At 2:45 PM on the first floor, a third linen cart had no washcloths and 2 stained bath towels. On 12/30/25 at 2:46 PM, V2 (Director of Nursing) was shown the stained towel on the linen cart and V2 stated, I wouldn't want to use it. V2 stated the staff call the laundry for linen when needed and the residents prefer disposable wipes instead of the towels.On 01/02/26 at 4:15 PM, V2 stated the CNAs (Certified Nursing Assistants) voiced concerns regarding not having enough linen to provide resident care. On 1/2/26 at 10:21 AM, 1st floor linen carts had no washcloths or bath towels in them. On 1/2/25 at 10:54 AM, 2nd floor linen cart on odd side rooms had only 2 washcloths & 2 bath towels left. On 12/31/25 at 11:13 AM, R18 stated they were concerned the facility eliminated the use of disposable wipes and switched to using washcloths for cleaning residents. R18 stated she was unable to find a washcloth in the facility that was usable because some still appeared soiled after being laundered. R18 stated some of the linens appeared so stained that she did not want to put them on her body. R18 stated she threw some linens away because they came to her stained and she also cut up towels to make washcloths for herself. R18 stated the residents at the resident council meeting the day prior expressed several concerns regarding the lack of, and condition of, facility linens. On 12/30/25 at 10:45 AM, R19 (Resident Council [NAME] President) stated residents complain about the towels and linens. R19 stated on 12/30/25 there were no towels on the first floor for use during her shower and R19 went upstairs to look for towels. R19 stated the second-floor linen carts had no towels so she washed up with a paper towel. R19 lifted her bed sheet and there was a large round brown stain on her fitted sheet. R19 stated her fitted sheet was placed on her bed with the stain already present and R19 placed two incontinence bed pads on top of it because she thought it was nasty. R19 stated the towels were not clean and most were stained, had feces on them, and stink. R19 stated she spoke with V2 (Director of Nursing) about the facility obtaining more linen and the facility CNAs (Certified Nursing Assistants) call down to the laundry to request more linens. R19 stated she spoke with V1 (Administrator) and V1 reported he ordered more linens. R19 stated V1 was ordering linens and the residents/staff were cutting up the towels to make washcloths or throwing the towels out. R19 stated the linens were a concern for more than three weeks and some of the family/residents/ staff were purchasing their own disposable wipes (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	themselves. On 1/6/ 26 at 10:15 AM, R26 stated he purchased his own towels and supplies because the facility ran out of linens. On 1/2/26 at 10:27 AM, R25 said there were several days on which she asked for washcloths and the staff replied there were no washcloths. R25 stated she had to cut towels to use the towel pieces as washcloths. On 12/30/25 at 2:22 PM, R24 stated the facility washcloths used for residents were stained and dirty and there were not enough linens in the facility for resident incontinence care so R24 was purchasing her own disposable wipes. On 12/30/25 at 2:28 PM, V7 (CNA - Certified Nursing Assistant) stated, It's horrible regarding the linen supply situation at the facility. V7 stated there were no washcloths or towels available for resident care in the facility. V7 stated she personally purchased her own washcloths for use on residents during her shift and disposed of them after use. V7 stated the staff were supposed to use linens supplied by the facility and placed on linen carts but there often were none in stock. V7 stated she worked at the facility for two months and there were not enough linens each time she worked since she started. On 12/30/25 at 2:40 PM, V5 (LPN - Licensed Practical Nurse) stated, The linens are disgusting. Would you use them?! On 12/31/25 at 5:16 PM, V5 stated there were not enough supplies, and she had seen linen come off the cart improperly cleaned. On 12/30/25 at 2:48 PM, V6 (CNA) said there was a lack of linens at the facility and when she did not have enough linens, she used a piece of tissue to pat the resident dry and put their diaper on during incontinence care. On 12/31/25 at 12:22 PM, V19 (CNA) stated the facility does not have enough linens so she brought her own wipes from home to care for the residents. V19 stated when the linens come back from the laundry, they appear dirty and stained. On 12/30/25 at 3:00 PM, V11 (Laundry) stated she had no back up face cloths in the laundry room and was waiting on an order to come into the facility. V11 stated the facility makes a mid-day announcement to send down soiled linens to laundry for cleaning but the CNAs send soiled linens down toward the end of V11's shift and she could not clean the linens fast enough. V11 stated there were stains on some of the washcloths and towels, and she attempts to wash them twice to get the stains out, but some stains will not come out. Resident Council Meeting Minutes, dated 10/21/25, 11/18/25, and 12/30/25, shows the residents stated they wanted their linen changed more frequently. Resident Council Meeting Minutes, dated 12/30/25, show the residents requested more of a variety of linens to be available and requested stronger/different materials facial wash cloths.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to provide timely incontinence care to residents who required staff assistance for ADLs (Activities of Daily Living). This applies to 2 of 4 residents (R17 and R20) observed for incontinence care in a sample of 35. The findings include: 1. On12/31/25 at 12:58 PM, R17 stated he had not had incontinence care since he got out of bed in the morning. V19 (CNA/Certified Nursing Assistant) assisted R17 back to bed for incontinence care. R17 was wearing two incontinence briefs. R17's brief had a small amount of thick feces and blood. R17's buttocks, sacrum and scrotum were excoriated, and the left abdominal fold was excoriated and bleeding. R17 stated wearing two incontinence briefs was standard procedure so he did not urinate through his clothing while waiting for assistance. V19 stated she usually placed two incontinence briefs on R17. V19 stated she is unable to get to him with so many people to care for. V19 stated she saw residents every two hours, so she puts the extra undergarment on as a liner to keep his clothes dry. On 12/31/25 at 12:22 PM, V19 stated when she was assigned sixteen residents, and did not get everything done, she informed the nurse. V19 said if she cannot provide incontinence care or lay them down, she would relay her concerns to the nurse. V19 stated R17 had some excoriation from sitting in a wet brief all day and the urine tore his skin up. V19 stated R17 does not refuse to lay down to have his brief changed. V19 stated R17 was last changed at about 7:30 AM when he got out of bed. R17's care plan showed an alteration in skin integrity with a stage 2 pressure sore on the left buttock and is at risk for additional and or worsening of skin integrity issue related to incontinence of bladder, incontinence of bowel, impaired mobility status, diabetes, comorbidities. R17's interventions included the resident being checked for incontinence as needed and peri care given. 2. On 12/30/25 at 4:12 PM, V6 (CNA/Certified Nurse Assistant) provided incontinence care to R20. V6 opened R20's brief and R20 was wearing two incontinence briefs. R20's brief was saturated with urine and stool, and his scrotum was large and reddened. On 12/30/25 at 4:30 PM, V6 stated the two briefs were placed on R20 by the previous shift staff. V6 stated residents should not have two disposable briefs on at the same time because it was bad for the resident's skin. R20's Care Plan shows R20 was incontinent of bowel and bladder and R20's interventions included cleaning R20's peri area with each incontinence episode. 3. Facility Resident Council Meeting Minutes, dated 10/21/25, 11/18/25 and 12/30/25, show residents expressed concerns about call light response times and follow up from staff to residents varies. The minutes also show residents expressed concern the staff were turning off call lights prior to being requested. On 01/02/26 at 4:15 PM, V2 (DON/Director of Nursing) stated none of the residents should have two incontinence briefs on unless they were educated and care planned for resident preference. V2 said using double briefs may lead to skin break down and UTIs if they were not changed. V2 said incontinent residents should be checked every two hours and as needed for the need of incontinence care. The facility policy Incontinence Care dated 1/2025 states residents were to be checked periodically for bowel and or bladder incontinence and be provided perineal and genital care to prevent infection and improve the quality of resident's care. The policy shows any resident, with or without an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interviews and record reviews, the facility failed provide timely medication administration per facility policy. This applies to 9 residents (R6, R8, R10, R12, R15, R19, R22, R25, and R27) reviewed for medication administration in a sample of 35. The findings include: 1. The EMR (electronic medical record) showed R19 was cognitively intact. On 12/30/25 at 10:45 AM, R19 (Resident Council [NAME] President) stated the facility residents complain about receiving late medications, waiting long periods for their call lights to be answered, and not having enough staff at the facility. Review of R19 medication administration times on document titled Medication Admin Audit Report showed: -On 1/2/26, Buspirone, Lamotrigine, Dicyclomine was scheduled for 5:00 PM and was administered by the nurse at 6:39 PM. R19's Trazadone, Ezetimbe, Dicyclomine and Lidocaine patch were scheduled for 9:00 PM and was given at 10:22 PM. R19's Mirtazapine was scheduled for 9:00 PM and was given at 10:23PM. -On 1/3/26, Lomotil was scheduled for 4:00 PM and administered by the nurse at 6:26 PM, and R19's Dicyclomine Gabapentin and Buspirone was scheduled for 5:00 PM and was administered at 6:27PM. -On 1/4/26, Lomotil was scheduled for 4 PM and was administered by the nurse at 6:24 PM, Biofreeze cream was scheduled for 5:00 PM and administered at 6:26 PM, Dicyclomine, Gabapentin, Buspirone was scheduled for 5 PM and was given at 6:27 PM, Lamatrogine and Propranolol was scheduled for 5:00 PM and was given at 6:28 PM, and Micatin cream was scheduled for 4:30 PM and was given at 6:31 PM. On 12/30/25 at 2:06 PM, V5 (LPN/Licensed Practical Nurse) stated she was the only nurse for 32 residents but months prior she only had 25 residents. V5 stated she was nonstop busy, could not take breaks, and was just surviving every shift. Facility document Policy and Procedure Administering Medications with issue date 1/1/2020 revision date 1/2025, shows Purpose to sure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Procedure.6 Medications should be administered within one (1) hour of prescribed times. 2. The EMR showed R22 was cognitively intact.On 1/2/26 at 2:28 PM R22 stated the nurses say they are busy and tell the residents they will get there medication when they get there. R22 stated the medications, especially as needed pain medications, are administered late by nurses. Review of R22's medication administration times on document titled Medication Admin Audit Report showed: - On 1/2/26, Zinc Oxide Cream was scheduled at 3:00 PM and was administered by the nurse at 7:47 PM - On 1/3/26, Buspirone was scheduled at 5:00 PM and given at 6:15 PM, Metformin was scheduled at 5:00 PM and was given at 6:18 PM, Probiotic capsule was scheduled at 5:00 PM and given at 6:15 PM, Bupren/nalox was scheduled at 5:00 PM and given at 6:15 PM, Omeprazole was scheduled at 5:00 PM and was given at 6:15 PM and blood glucose monitoring (Accucheck) was scheduled for 5:00 PM and was performed at 6:15 PM. -On 1/4/26, Bupren/nalox was scheduled at 9:00 PM and given at 10:22 PM, Lipitor was scheduled at 9:00 PM and given at 10:40 PM, Gabapentin was scheduled for 9:00 PM and given at 10:40 PM, Glargin YFGN sol was scheduled for 9:00 PM and was given at 10:40 PM, Trazadone was scheduled at 9:00 PM and was given at 10:40 PM, and Amitriptylin was scheduled for 9:00 PM and given at 10:40 PM 3. Review of R25's EMR showed R25 was cognitively intact. On 1/5/26 at 3:00 PM, R25 stated their blood glucose check was supposed to be completed on 1/3/25 and the nurse was out of testing strips. R25 stated the nurse told R25 she had to get testing strips from upstairs, and that she should not have to look for supplies. R25 stated she called the nurse at 9:00 PM because her blood sugar should have been checked at 5:00 PM and R25 should have received insulin at 6:00 PM but had not yet received it. R25 stated several residents complained nurses gave the wrong medications, gave insulin too late, and gave the wrong dose of medications at the facility. Review of R25's medication administration times on document titled Medication Admin Audit Report showed: - On 1/3/26, Insulin Glargine was scheduled for 6:00 PM and was administered by the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse at 8:30 PM. - On 1/4/26, Insulin Lispro was scheduled for 5:00 PM and was administered at 7:13 PM, Dicyclomine was scheduled at 5PM, and was administered at 7:19 PM -On 1/4/26, Insulin Glargine was scheduled at 6:00 PM and was administered at 7:19 PM. 4. The EMR showed R12 was cognitively intact. On 1/5/26 at 3:27 PM, R12, stated there have been issues with medications being late and his medications were often late. R12 stated they received medications late this weekend. Review of R12's medication administration times on document titled Medication Admin Audit Report given by facility personnel showed: -On 1/4/26, Colesevelam was scheduled at 5:00 PM and was administered by the nurse at 6:18 PM and Colace was scheduled at 5:00 PM and was administered at 6:30 PM. 5. The EMR showed R27 was cognitively intact. On 1/5/26 at 2:50 PM, R27 stated the afternoon 3:00 PM -11:00 PM shift nurses pass medications late. R27 stated once he was supposed to get his diabetic medications at 6:00 PM but did not get the medication until 9:00 PM. R27 stated he asked the nurse at 7:00 PM for his medications due at 6:00 PM and the nurse replied she would get it when she could. R27 stated the nurse had a bad attitude when he approached her again at 8:30 PM asking for his medication and the nurse responded, You'll get it when I can get to you. Review of R27's medication administration times on document titled Medication Admin Audit Report showed: -On 1/3/26, Atorvastatin was scheduled for 8:00 PM and was administered by the nurse at 9:17 PM, Humalog Insulin was scheduled for 4:30 PM and given at 6:18 PM, -On 1/4/26 Metformin was scheduled for 5:00 PM and was given at 6:18 PM. 6. The EMR showed R15 was cognitively intact. On 12/31/ at 10:31 AM, R15, stated she felt like there were not enough nursing staff in the facility. Review of R15's medication administration times on document titled Medication Admin Audit Report showed: - On 1/2/26, Carvedilol was scheduled for 5:00 PM and was administered by the nurse at 8:36 PM, blood glucose monitoring (Accucheck) was scheduled for 5:00 PM and was taken at 8:36 PM. 7. The EMR showed R10 was severely cognitively impaired. Review of R10 medication administration times on document titled Medication Admin Audit Report showed: -On 1/2/26 Brimonidine Tartrate ophthalmic solution, timolol ophthalmic, and Zostrix cream was scheduled for 6:00 PM and was administered by the nurse at 8:20 PM. R10's blood glucose monitoring was scheduled for 6:00 PM and was completed at 8:20 PM. -On 1/3/26 R10's blood glucose monitoring was scheduled for 5:00 PM and was completed at 6:41 PM. On 1/4/26 R10's Insulin (Glargine) and Terazosin capsule were scheduled for 8:00 PM and was administered by the nurse at 9:21 PM. 8. R8 The EMR showed R8 was cognitively intact. Review of R8 medication administration times on document titled Medication Admin Audit Report showed: -On 1/2/26 Insulin Lipro was scheduled for 7:30 AM and was administered by the nurse at 10:34 AM. Insulin Glargine, Pregablin, Buspirone, Ascorbic acid, Empaglifozin, furosemide, Atorvastatin, Famotidine, Duloxetine, Folic acid, ferrous sulfate was scheduled at 9:00 AM and was given at 10:30 AM, Buprenophrine was scheduled for 12:00 PM and was given at 1:26 PM 9. On 1/7/25 at 1:24 PM, R6 stated she waited more than two hours to receive medications. On 12/31/25 at 11:24 AM V18 (CNA) stated R6, used the call light and sometimes complained the nurses may not give her medications because her room was on the far end of the hallway. 10. Facility Resident Council Meeting Minutes, dated 10/21/25, 11/18/25 and 12/30/25, show residents expressed concerns about call light response times and follow up from staff to residents varies. The minutes also show residents expressed concern the staff were turning off call lights prior to being requested.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review the facility failed to provide incontinence care utilizing techniques per facility protocols and policy. This applies to 3 of 3 residents (R13, R15, and R20) reviewed for incontinence care in a sample of 35. The findings include: 1. On 12/30/25 at 4:12 PM, V6 (CNA/Certified Nursing Assistant) provided incontinence care to R20. V6 opened R20's brief which was saturated with urine and his scrotum was large and reddened. V6 removed the soiled undergarment and wiped R20's penis and scrotum several times with the same washcloth. V6 then wiped R20's feces covered buttocks with the same washcloth and followed with wiping his rectum and buttocks with the soiled washcloth. R20's buttocks were scantly smeared with feces. V6 stated the facility did not use disposable wipes anymore to provide incontinence care and instead use non-disposable washcloths. V6 stated if disposable wipes were available, it would be used once and tossed away. V6 stated the towels usually run out at the facility. V6 stated she only had one towel for the incontinence care and she did the best she could with the supplies available. R20's incontinence care plan showed R20 was incontinent of bowel and bladder and interventions included cleaning R20's peri area after each incontinence episode. 2. On 12/30/25 at 2:43 PM, V6 (CNA) provided incontinence care to R13. V6 sated she was able to find one washcloth on the linen cart. V6 wet the washcloth and wiped R13's groin areas starting from the right side to the left side, and then down the perineal area. V6 turned R13 to the right side and used the same washcloth to wipe R13's perianal area. R13's incontinence care plan showed R13 was incontinent of bowel and bladder and interventions included cleaning R13's peri area after each incontinence episode. 3. On 12/31/25 at 10:31 AM, V7 (CNA) provided incontinence care to R15. V7 had one washcloth and one towel to provide care for R15. V7 wet the bath towel and wiped the groin, perineal area, and perianal areas with the towel. V7 turned R15 to the right side and cleaned R15's perianal area with stool. V7 then used a wet paper towel to wipe down the soapy areas from the resident's perineal area. R15's incontinence care plan showed R15 was incontinent of bowel and bladder and interventions included cleaning R15's peri area after each incontinence episode. On 01/02/26 at 4:15 PM, V2 (DON/Director of Nursing) stated the CNAs (Certified Nursing Assistants) voiced concerns regarding not having enough linen to provide resident care. V2 stated the facility did not use disposable wipes but used washcloths and bath towels for incontinence care. V2 stated the staff should only swipe once with each clean washcloth when using non-disposable linen during incomitance/periarea care. V2 stated the staff would not be able to meet facility incontinence care expectations if there were not enough linens available in the facility. The facility policy Incontinence Care dated 1/2025 states residents will be checked periodically for bowel and or bladder incontinence and be provided perineal and genital care to prevent infection and improve the quality of resident's care. The policy shows a resident with or without an indwelling catheter receives the appropriate care and services to prevent urinary tract infections to the extent possible.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interviews and record reviews, the facility failed to staff sufficient nurses for proper incontinence care and timely medication administration. This applies to 11 residents (R6, R8, R10, R12, R15, R17, R19, R20, R22, R25, and R27) reviewed for staffing in a sample of 35.The findings include: 1. R17's care plan showed an alteration in skin integrity with a stage 2 pressure sore on the left buttock and is at risk for additional and or worsening of skin integrity issue related to incontinence of bladder, incontinence of bowel, impaired mobility status, diabetes, comorbidities. On 12/31/25 at 12:58 PM, R17 stated he had not had incontinence care since he got out of bed in the morning. V19 (CNA/Certified Nursing Assistant) performed incontinence care on R17 who was wearing two incontinence briefs. R17's brief had a small amount of thick feces and blood, his buttocks, sacrum and scrotum were excoriated, and the left abdominal fold was excoriated and bleeding. R17 stated wearing two incontinence briefs was standard procedure so he did not urinate through his clothing while waiting for assistance. V19 stated she usually placed two incontinence briefs on R17 because she is unable to get to him with so many people to care for. V19 stated she sees everyone every two hours, so she puts the extra undergarment on as a liner to keep his clothes dry. At 12:22 PM, V19 stated when she has been assigned sixteen residents, and she does not get everything done, she informs the nurse. V19 said if she cannot provide incontinence care or lay them down, she will relay it to the nurse. V19 stated R17 has some excoriation from sitting in a wet brief all day and the urine tears his skin up. V19 stated R17 does not refuse to lay down to have his brief changed. V19 stated R17 was last changed at about 7:30 AM when he got out of bed. 2. R20's Care Plan includes incontinence of bowel and bladder, with a goal to remain free from skin breakdown due to incontinence and brief use. R20's interventions included to clean peri area with each incontinence episode. On 12/30/25 at 4:12 PM, V6 (CNA/Certified Nurse Assistant) provided incontinence care to R20. V6 opened R20's brief and R20 was wearing two incontinence briefs. R20's brief was saturated with urine and stool and his scrotum was large and reddened. At 4:30 PM, V6 stated the two briefs were placed on R20 by the previous shift. V6 stated residents should not have two disposable briefs on at the same time because it was bad for the resident's skin. On 01/02/26 at 4:15 PM, V2 (DON/Director of Nursing) stated none of the residents should have two incontinence briefs on unless they were educated and care planned for resident preference. V2 said using double briefs may lead to skin break down and UTIs if they were not changed. V2 said incontinent residents should be checked every two hours and as needed. The facility policy Incontinence Care, dated 1/2025, states residents will be checked periodically for bowel and or bladder incontinence and be provided perineal and genital care. The document states a resident, with or without an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible. 3. The EMR (electronic medical record) showed R19 was cognitively intact. On 12/30/25 at 10:45 AM, R19 (Resident Council [NAME] President) stated the facility residents complain about receiving late medications, waiting long periods for their call lights to be answered, and not having enough staff at the facility.Review of R19 medication administration times on document titled Medication Admin Audit Report showed: -On 1/2/26, Buspirone, Lamotrigine, Dicyclomine was scheduled for 5:00 PM and was administered by the nurse at 6:39 PM. R19's Trazadone, Ezetimbe, Dicyclomine and Lidocaine patch were scheduled for 9:00 PM and was given at 10:22 PM. R19's Mirtazapine was scheduled for 9:00 PM and was given at 10:23PM. -On 1/3/26, Lomotil was scheduled for 4:00 PM and administered by the nurse at 6:26 PM, and R19's Dicyclomine Gabapentin and Buspirone was scheduled for 5:00 PM and was administered at 6:27PM. -On 1/4/26, Lomotil was scheduled for 4 PM and was administered by the nurse at 6:24 PM, Biofreeze cream was scheduled (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for 5:00 PM and administered at 6:26 PM, Dicyclomine, Gabapentin, Buspirone was scheduled for 5 PM and was given at 6:27 PM, Lamatrogine and Propranolol was scheduled for 5:00 PM and was given at 6:28 PM, and Micatin cream was scheduled for 4:30 PM and was given at 6:31 PM. Facility document Policy and Procedure Administering Medications with issue date 1/1/2020 revision date 1/2025. The document shows Purpose to sure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Procedure.6 Medications should be administered within one (1) hour of prescribed times. 4. The EMR showed R22 was cognitively intact. On 1/2/26 at 2:28 PM R22 stated the nurses say they are busy and tell the residents they will get there medication when they get there. R22 stated the medications, especially as needed pain medications, are administered late by nurses. Review of R22's medication administration times on document titled Medication Admin Audit Report showed: - On 1/2/26, Zinc Oxide Cream was scheduled at 3:00 PM and was administered by the nurse at 7:47 PM - On 1/3/26, Buspirone was scheduled at 5:00 PM and given at 6:15 PM, Metformin was scheduled at 5:00 PM and was given at 6:18 PM, Probiotic capsule was scheduled at 5:00 PM and given at 6:15 PM, Bupren/nalox was scheduled at 5:00 PM and given at 6:15 PM, Omeprazole was scheduled at 5:00 PM and was given at 6:15 PM and blood glucose monitoring (Accucheck) was scheduled for 5:00 PM and was performed at 6:15 PM. -On 1/4/26, Bupren/nalox was scheduled at 9:00 PM and given at 10:22 PM, Lipitor was scheduled at 9:00 PM and given at 10:40 PM, Gabapentin was scheduled for 9:00 PM and given at 10:40 PM, Glargin YFGN sol was scheduled for 9:00 PM and was given at 10:40 PM, Trazadone was scheduled at 9:00 PM and was given at 10:40 PM, and Amitriptylin was scheduled for 9:00 PM and given at 10:40 PM.5. Review of R25's EMR showed R25 was cognitively intact. On 1/5/26 at 3:00 PM, R25 stated their blood glucose check was supposed to be completed on 1/3/25 and the nurse was out of testing strips. R25 stated the nurse told R25 she had to get testing strips from upstairs, and that she should not have to look for supplies. R25 stated she called the nurse at 9:00 PM because her blood sugar should have been checked at 5:00 PM and R25 should have received insulin at 6:00 PM but R25 had not yet received them. R25 stated several residents complained nurses gave the wrong medications, gave insulin too late, and gave the wrong dose of medications at the facility. Review of R25's medication administration times on document titled Medication Admin Audit Report showed: - On 1/3/26, Insulin Glargine was scheduled for 6:00 PM and was administered by the nurse at 8:30 PM. - On 1/4/26, Insulin Lispro was scheduled for 5:00 PM and was administered at 7:13 PM, Dicyclomine was scheduled at 5PM, and was administered at 7:19 PM -On 1/4/26, Insulin Glargine-yfgn was scheduled at 6:00 PM and was administered at 7:19 PM. 6. The EMR showed R12 was cognitively intact. On 1/5/26 at 3:27 PM, R12, stated there have been issues with medications being late and his medications were often late. R12 stated they received medications late this weekend. Review of R12's medication administration times on document titled Medication Admin Audit Report given by facility personnel showed: -On 1/4/26, Colesevelam was scheduled at 5:00 PM and was administered by the nurse at 6:18 PM and Colace was scheduled at 5:00 PM and was administered at 6:30 PM. 7. The EMR showed R27 was cognitively intact. On 1/5/26 at 2:50 PM, R27 stated the afternoon 3:00 PM -11:00 PM shift nurses pass medications late. R27 stated he was supposed to get his diabetic medications at 6:00 PM but did not get the medication until 9:00 PM. R27 stated he asked the nurse at 7:00 PM for his medications due at 6:00 PM and the nurse replied she would get it when she could. R27 stated the nurse had a bad attitude when he approached her again at 8:30 PM asking for his medication and the nurse responded, You'll get it when I can get to you. Review of R27's medication administration times on document titled Medication Admin Audit Report showed: -On 1/3/26, Atorvastatin was scheduled for 8:00 PM and was administered by the nurse at 9:17 PM, Humalog Insulin was scheduled for 4:30 PM and given at 6:18 PM. -On 1/4/26 Metformin (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145338	A. Building B. Wing	01/13/2026

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