STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Nursing & Rehab Center	4900 North Bernard Chicago, IL 60625

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F554Based on observations, interviews, and record reviews the facility failed to: 1. Obtain a physician order to keep medication at bed side for two (R107, and R126).2. Determine if self-administration of medication was appropriate for one (R107) out of two residents observed with medications at bed side table in a sample of 35. Findings Include:R107's Minimum Data Set/ MDS dated [DATE], Brief Interview Score (14) indicates she is cognitively intact. R107's Physician Order Sheet (POS) with active orders as of 8/5/25 shows Ventolin HFA inhalation aerosol solution 108 (90 base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 6 hours as needed for shortness of breath. R126's Minimum Data Set/ MDS dated [DATE], Brief Interview Score (15) indicates he is cognitively intact. R126's Physician Order Sheet (POS) with active orders as of 8/5/25 shows Ventolin HFA inhalation aerosol solution 108 (90 base) MCG/ACT 2 puff inhale orally every 6 hours as needed for shortness of breath. On 8/5/25 at 11:23 AM, Surveyor entered R107 and R126's room, observed two dispenser containing Ventolin HFA inhalation aerosol solution at bed side tables. Both stated they have been having the dispensers at the bed side for over a month, and they have used the inhaler today. On 8/6/25 at 10:08 AM, surveyor and V28 (Licensed Practical Nurse/LPN) entered R107 and R126's room and observed Ventolin inhalation dispenser at R107, and R126's bed side table. V28 identified the medications as Ventolin HFA inhalation aerosol solution 108 (90 base) MCG/ACT Albuterol Sulfate Inhaler, stated that medication should not be left at the bed side table to prevent misuse or overuse. She also stated that there should be a physician order to keep inhaler at bed side, to self-administer, and an assessment to determine if the resident could self-administer safely. On 8/7/25 at 11:12 AM, V2 (Director of Nursing/DON) stated that for any resident to keep medication at bed side for self-administration, there should be a physician order, and medication self-administration safety assessment to prevent overdose and other resident taking the medication. R107's clinical records had no documentation to show a self-administration of medication assessment was completed, and physician order for self-administration to keep medication at bed side was found.R126's clinical records had no documentation/physician order for self-administration or to keep medication at bed side was found.The facility policy titled, Self-Administration of medications by residents dated 3/2023; documents in part: A physician order is obtained to self-administer medications if the above storage and skill assessment has been approved for the resident by the interdisciplinary team. The order is recorded on the MAR.

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
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure wheelchair armrest was not worn out or wabbly for 1 resident (R101) and failed to ensure call light were within reach and in good working order for four residents (R7, R17, R51, R98) reviewed for reasonable accommodation of needs out of a sample of 35. The findings include: R101's admission record showed initial admit date on 7/15/2009 with diagnoses not limited to Epilepsy, Unspecified asthma, Hypertensive heart disease, Pain in unspecified joint, Benign prostatic hyperplasia, Pain in left ankle and joints of left foot, Personal history of traumatic brain injury. MDS (Minimum Data Set) dated 7/11/2025 showed R101's cognition was intact. He needed set up or clean up assistance with eating; Supervision or touching assistance with chair / bed and toilet transfer. MDS showed R101 uses wheelchair and received restorative nursing programs for active range of motion (AROM), splint or brace assistance and transfer 7 days in a week. On 8/05/2025 at 10:57AM Observed R101 sitting on the side of the bed, alert and oriented x 3, verbally responsive. Stated his wheelchair armrest is broken and told staff about it but never took care of it. R101 said he needed a new wheelchair because it is falling apart, so it was taped. Observed wheelchair armrests (right and left) were worn out and wabbly with blue tape around it. On 8/6/25 At 12:39PM V29 (MAINTENANCE DIRECTOR) stated he has been rounding and checking resident's wheelchair and equipment on daily basis. He said did not happen to see tape on R101's wheelchair armrest. V29 said when an equipment or device is taped or broken it is not good and not safe to use it should be taking care of right away. On 8/6/25 At 2:25PM V43 (RESTORATIVE NURSE, LPN) – has been working in the facility for 3 years. She said R101 is using an electric wheelchair and is on restorative NURSING program for AROM upper and lower extremities. V43 said Restorative aide is seeing R101 5 days a week. She said no report received regarding R101's wheelchair broken or falling apart but she said R101 mentioned that he needed a new wheelchair. V43 said If resident's wheelchair is broken it is not safe to use. On 8/6/25 At 3:10pm V43 said she saw R101's wheelchair armrest (right and left) was worn out, wabbly and there was tape on both sides. On 8/7/25 at 11:49AM V2 (Director of Nursing / DON) said equipment like wheelchair use by resident should be functioning or working properly, not worn out, or damage for resident's safety. Findings Include: R51's Minimum Data Set (MDS) dated [DATE], Brief Interview Score (15) indicates he is cognitively intact. R51 Physician Order Sheet (POS) dated 8/5/25 shows an active diagnosis of multiple sclerosis, repeated fall, other muscle spasm, ataxic, asthma, migraine intractable, syncope and collapse. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/25 at 10:55 AM, R51 received in bed, call light not visible, stated that he has been in this facility for six months, and he has no call light since. He also stated that, because he has no call light, he would not be able to call for help to receive care as needed. On 8/6/25 at 9:06 AM, R51 received in bed, call light not within reach, stated no one care to listen to him. V25 (Certified Nursing Assistant/CNA) entered R51's room to pull the call light string from the floor underneath R51's roommate dresser and she attached the call light to R51's bed sheet. She stated because the call light is not within reach, R51 could fall when trying to reach for the call light under the dresser. On 8/7/25 at 11:12 AM, V2(Director of Nursing/DON) stated that she has been in the facility for three months and she expects that all residents will have call light attached within reach to alert staff for help as needed, and for safety. V18 (Licensed Practical Nurse/LPN), and V21 (CNA) Both stated that staff should make sure the call lights are within reach of the residents at all times. Facility policy titled Call Light, Use of dated 1/1/20, documents in part: Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand. R7 has diagnosis not limited to Need for Assistance with Personal Care, Hypertensive Heart Disease, Type 2 Diabetes Mellitus with Hyperglycemia, Dysphagia, Myocardial Infarction, Cognitive Communication Deficit, Atherosclerotic Heart Disease, Chronic Embolism and Thrombosis, Vascular Dementia, Major Depressive Disorder, Convulsions, Gastrostomy, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Anoxic Brain Damage, Acute Kidney Failure, Acidosis and Acute Respiratory Failure with Hypoxia. R7'S MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 99 indicating resident is rarely/never understood. R7's Care Plan document in part: Focus: R7 is at Risk for Falls as evidenced by the following risk factors and potential contributing Diagnosis: Anoxic brain damage, CVA (Cerebral Vascular Accident). Interventions: Place my call light within reach and encourage me to use it for assistance as needed. Focus: Side Rails: I could benefit from use of Non-Restrictive Side Rail(s) or devices to improve, and/or maintain my functional bed mobility independence and promote healthy skin integrity. The use of the devices will enable me to become more self-sufficient in positioning and turning while in bed, enable my participation sitting up in bed and lastly to enable me to assist with my transfer in and out of my bed. Grab Bar(s) (Halo), General Weakness with impaired strength and endurance, CVA with Hemiparesis or Hemiplegia, Impaired Cognition, Impaired Communication. Interventions: Place my call light within reach and encourage me to use it for assistance as needed. On 08/05/25 at 12:39 PM R7 was observed lying in bed. R7's call light was observed positioned on the floor near the left side of the headboard out of R7's reach. V41 (Certified Nurse Assistant) entered R7's room. Surveyor asked R7 the location of R7's call light. V41 responded on the floor. V31 proceeded to the head of R7's bed, picked up the call light cord and attached it to R7's pillow. On 08/07/25 at 12:25 PM V2 (Director of Nursing) stated The call light should be placed on the side, attached to the gown or clothes depending on the individual. The call light should be within reach, in case the resident need something or need to go to the bathroom. It is for safety. On 08/07/25 at 04:53 PM V1 (Administrator) provided a document titled Education Record dated 08/05/25 Call Light Policy. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings include: On 08/05/25 at 11:14 AM, observed R17 and R98 residing in the same room with R98 in the first bed position and R17 in the 3rd bed position. On 08/05/2025 at 11:15 AM, observed R98 lying in bed. There was no call light within R98's reach. Observed call light switch located on the wall however there was no string or cord attached to the switch. R98 stated when he needs help from the staff he uses his call light. R98 said, the call light is right here and he grabbed onto the string attached to the over the bed light switch and pulled it continually which turned the over the bed light on and off. R98 stated he just needs to wait now for one of the staff to come. On 08/05/25 at 11:18 AM, observed R17 lying in bed. R17's bed was in the lowest position with a floor mat next to his bed. R17's call light not within reach. Upon further observation there was no string attached to R17's call light switch on the wall near his bed. On 08/05/25 at 11:18 AM, V11 (Registered Nurse Trainee) stated he does not see R17's or R98's call light. V11 said, I'm trying to find them. They are both missing the string which attaches to the call light switch on the wall. V11 stated there should be a string attached to the switch on the wall so that R17 and R98 can activate their call lights by pulling on the string. V11 stated the problem with V17 and R98 not having access to their call light is when they are in distress or need something they cannot alert the staff. On 08/05/25 at 11:22 AM, observed V12 (Certified Nursing Assistant) attaching a string to the call light switch on the wall. V12 stated she is attaching a string to R17 and R98's call light so they can have use of the call light because the string was missing. V12 stated someone should have noticed and replaced the string. V12 stated the extra string is kept at the nursing station. V12 stated all the residents should have access to a call light in case something happens, and they need the staff. V12 stated after giving care to a resident she always makes sure the resident's call light is within their reach. V12 stated this is important because most of the residents including R17 and R98 are at fall risk and the staff does not want them to try to get up on their own. On 08/07/25 at 9:50 AM, V2 (Director of Nursing) stated all residents should have access to a call light and call lights should be within their reach. V2 stated having call lights within the resident's reach and in working order is important in case they need assistance from the staff so they can alert the staff that they need help or assistance. V2 stated not having access to a call light is also a safety concern because if a resident needs to go to the bathroom and they are not able to contact the staff they may try to get up by themselves which could potentially risk a fall. R17 has diagnosis which includes but not limited to Gout, Inflammatory Disorders of Scrotum, Anxiety Disorder, Unspecified Psychosis, Unspecified Severe Protein Calorie Malnutrition, Age-Related Osteoporosis, Wedge Compression Fracture of First Lumbar Vertebra, Sophronia, Abnormalities of Gait Immobility, Unspecified Dementia, Dysphasia, Adult Failure to Thrive, Unspecified Hearing Loss. R17's MDS (Minimum Data Set) dated 07/21/25 documents in part, partial/moderate assistance for toileting hygiene and mobility including transfers. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R17's fall care plan documents in part R17 is at risk for falls with goal for R17 to have a safe environment and intervention includes but not limited to place my call light within reach and encourage (R17) to use it for assistance as needed. R98 has diagnosis which includes but not limited to Myasthenia Gravis, Hypertensive Heart Disease, Type 2 Diabetes Mellitus, Schizophrenia, Shortness of Breath, Long Term Use of Anticoagulants (Current), Long Term Use of Insulin (Current), Long Term Use of Oral Hypoglycemic Drugs (Current), Pain in Left Hip. R98's MDS dated [DATE] documents in part, BIMS (Brief Interview for Mental Status) score indicating moderate cognitive impairment and requires partial/moderate assistance with toileting hygiene and supervision/touching assistance with chair/bed to chair transfer. R98's fall care plan documents in part, R98 is at risk for falls as evidenced by the following risk factors including decreased strength and endurance, episodes of incontinence of bowel and bladder, respiratory disorders with increased risk for shortness of breath. R98's fall care plan goal includes but not limited to R98 will have a safe environment and intervention includes but not limited to place (R98) call light within reach and encourage (R98) to use it for assistance as needed. Facility provided policy titled Resident Rights undated which documents in part as a resident of this facility, you have the right to a dignified existence and the facility will protect and promote your rights as designated below: the facility must provide a safe, clean, comfortable, home-like environment, allowing you the opportunity to use your personal belongings to the extent possible. Facility provided policy titled, Call Light, Use of dated 01/01/20 which documents in part to assure call system is in proper working order and when providing care to residents be sure to position the call light conveniently for the resident to use and be sure all call lights are placed on the bed at all times, never on the floor or bedside stand.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Number of residents sampled: 172Number of residents cited: 3 Based on observations, interviews, and record reviews, the facility failed to ensure a homelike environment for three residents (R42, R88, R172) out of a total sample of 172 residents in the facility.Findings include: On 8/05/2025 at approximately 10:20 AM, R172 stated facility is slow to fix broken furniture and fixtures. R172 stated ceiling panel by the window has been missing for weeks. There was some type of leak from the ceiling and someone from maintenance took the panel out and never finished fixing it. When surveyor entered bedroom, surveyor observed the missing ceiling panel by R172's foot of the bed. Piping exposed and there were multiple towels and linen on the floor under the ceiling panel. On 8/05/2025 at 10:36 AM, R42 (roommate) stated the ceiling panel fell off and there was some water leak. R42 stated it's been this way for weeks. R42 stated the facility isn't doing anything to fix it or put it back. R42 also pointed to the cabinet in front of the bed. The left side panel and left cabinet door are missing. R42 stated the left side belonged to R88 (roommate). R42 stated the cabinet door fell off days ago and the facility hasn't fixed it. On 8/05/2025 at 3:39 PM, V31 (Housekeeping) stated R42 reported the broken cabinet previously but could not recall how long it's been broken. On 8/05/2025 at 3:43 PM, R42 stated cabinet has been broken for at least a week. On 8/06/2025 at 9:33 AM, the ceiling panel remained missing and there were towels on the floor. R88 stated has been in the room for a week now and the cabinet panel and door were broken when R88 moved in. R88 stated the maintenance and upkeep of the building could be a lot better. On 8/06/2025 at 12:31 PM, V29 (Maintenance Director) provided survey team with facility's work orders from 2/01/2025 through 8/06/2025. No mention of the ceiling panel or R88's cabinet. V29 stated was not aware of R88's cabinet until V1 (Administrator) notified V29 on 8/05/2025 late afternoon. V29 stated went into the room this morning and already fixed it. When asked about the ceiling panel, V29 did not know about the issue. V29 stated I hadn't noticed that it was gone. V29 stated staff have access to electronic reporting system and are supposed to put in any work order requests through there. Maintenance department will then review the work orders each morning to review which issues need priority. V29 stated maintenance team are also supposed to conduct daily inspections. On 8/06/2025 at 1:53 PM, V39 (Maintenance Assistant) and V29 stated they didn't know about the missing ceiling tile until surveyor informed them. Neither could provide information as to why the ceiling tile was missing or for how long. Facility's undated Resident Rights policy documents in part: The facility must care for you in a manner and environment that enhances or promotes your quality of life. The facility must provide a safe, clean, comfortable, home-like environment, allowing you the opportunity to use your personal belongings to the extent possible. The facility will provide housekeeping and maintenance services. The facility will provide you with private closet space as space permits. Facility's 'Preventative Maintenance Program' documents in part: Buildings and grounds are to be inspected daily. As areas needing repair or attention are identified, they should be dealt with immediately. If that is not possible, the issue and the area and/or resident room number should be recorded for proper follow up.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 35Number of residents cited: 1 Based on interviews and record reviews the facility failed to submit an accurate Level I PASRR (Pre-admission Screening and Resident Review) assessment for R10 and failed to refer R10 to the appropriate state-designated authority for a Level II PASRR evaluation and determination after a significant change for one out of a total sample of 35 residents. Findings include: On 8/05/2025 at 11:14 AM, R10 was sitting in bed staring at room curtain. Surveyor attempted to interview R10 but R10 was quiet and mostly to self with a flat affect. During other random observations, R10 was on the first floor dining room or walking in the hallway. R10 kept mostly to self with flat affect. On 8/05/2025 at approximately 11:30 AM, V17 (Nurse) stated that R10 is alert and oriented to person and place. V17 stated R10 used to be more alert but has considerably slowed down. V17 stated R10 is quieter, keeps to self and requires more encouragement and queuing now. On 8/05/2025 at 3:45 PM, R10 was sitting in a chair in R101's room. While R101 spoke with surveyor, R10 sat in a chair by the door. R10 was quiet with flat affect. Surveyor attempted to include R10 in conversation but R10 remained quiet. When R101 asked what was wrong, R10 did not answer. R101 continued to ask what was wrong and after a few minutes, tears formed in R10's eyes. R10 remained quiet and did not verbalize feelings. R10's 8/09/2023 ‘Notice of PASRR (Pre-admission Screening and Resident Review) Level I Screen Outcome' documents in part a determination of No Level II Required - No [Severe Mental Illness]/[Intellectual Disability]/[Related Condition]. The assessment did not include mental health diagnosis, behaviors and symptoms, or mental health medications. V54 (Office Manager) attested on [DATE] that R10's Level I was complete and accurate of information. R10's ‘admission Record,' however, documents in part diagnoses including but not limited to schizoaffective disorder, bipolar type (onset 5/29/2018), post-traumatic stress disorder (onset 5/29/2018), anxiety disorder (onset 5/29/2018), bipolar disorder (onset 12/02/2018), homicidal ideations (onset 12/02/2018), auditory hallucinations (onset 12/02/2018), and mild intellectual disabilities (onset 5/29/2018). R10's ‘Order Audit Report' also documents in part that R10 was on Haloperidol (antipsychotic) from 12/31/2022 through 2/20/2025 and Seroquel (antipsychotic) from 12/31/2022 through 11/30/2024. R10's current ‘Order Summary Report' documents in part that R10 is taking Risperdal for psychosis, Seroquel for schizoaffective disorder-bipolar type, and trazadone for insomnia. R10 is also taking non-psychiatric medications such as Hydroxyzine for anxiety disorder and Carbamazepine for behavior disturbances (off-label use). On 8/07/2025 at 2:25 PM, V54 (Office Manager) stated signing R10's 8/09/2023 Level I PASRR but did not do the assessment. V54 stated someone else did it but could not recall who. V54 stated [V54] is not clinical in practice. V54 stated when facility is short staffed in Social Services and Admissions Department, facility asks V54 to help sign and submit the PASRRs. V54 stated not knowing what [V54] was signing. ‘Level I Attestation and Signature' statement documents in part: By checking this box, I attest that I have reviewed all information contained herein and that I take responsibility for the completeness and accuracy of information reported throughout this submission. I attest that I am a health care professional working in a clinical capacity for this provider. I understand that approved submitters include clinical professionals such as nurses, [Licensed Practical Nurses], social workers (with a [Bachelor of Science] degree or higher), physicians, or home health agency clinical staff. Social service staff are not required to be licensed to submit information. I understand that administrative staff are not permitted to submit clinical information to [company name].I understand that Illinois PASRR considers knowingly submitting inaccurate, incomplete or misleading Level I information to be Medicaid fraud, and I have completed this form to the best of my knowledge. On 8/07/2025 at 11:33 AM, V48 (Social Service Director) stated the staff in charge of Admissions is supposed to oversee residents' PASRRs but there hasn't been a consistent Admissions person. V48 stated V52 (current Admissions) has been with facility for a week and is still learning. V48 is assisting with PASRRs but has not had a chance to review R10's PASRR. V48 stated it is important to have accurate PASRR assessments to ensure that the facility is appropriate for the residents and that the residents receive the services that they need. Further review of R10's MDS (Minimum Data Set) assessments document in part a significant change MDS dated [DATE]. On 8/07/2025 at 12:36 PM, V47 (MDS Nurse) stated R10's 7/06/2024 Significant Change MDS was due to R10 slowing down mentally and being more withdrawn. V47 stated R10 required more assistance with activities of daily living. On 8/07/2025 at 1:03 PM, V48 stated facility should have referred R10 to the appropriate state-designated authority for a Level II PASARR (Pre-admission Screening

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Number of residents sampled: 35Number of residents cited: 1 Based on interviews and record reviews, the facility failed to follow-up and refer a resident with mental illness (R78) to the appropriate state-designated authority for a Level II PASRR (Pre-admission Screening and Resident Review) evaluation and determination for one out of a total sample of 35 residents. Findings include: R78's 'admission Record' documents in part an initial admission date of 6/02/2025. Diagnosis information includes schizoaffective disorder, bipolar disorder, insomnia, and depression. R78's 'Clinical Physician Orders' include orders for Ziprasidone Hydrochloride for schizophrenia, Trazadone for insomnia, and Amitriptyline Hydrochloride for depression. R78's 5/31/2025 'Notice of PASRR (Pre-admission Screening and Resident Review) Level I Screen Outcome' documents in part a determination of Refer for Level II Onsite. Requested R78's Level II PASRR multiple times from V1 (Administrator), V2 (Director of Nursing), V33 (Social Service Coordinator), V36 (Nurse Consultant) and V48 (Social Service Director) throughout the course of the survey. On 8/06/2025 at 2:33 PM, V33 stated do not recall if R78 had a Level II assessment. On 8/07/2025 at 11:33 AM, V48 provided survey with a new PASRR Level I for R78 dated 8/07/2025. It also documents in part a determination of Refer for Level II Onsite. V48 does not think R78 ever received a Level II assessment. V48 stated the staff in charge of Admissions is supposed to follow-up with the PASRRs but there hasn't been a consistent Admissions person. V48 stated V52 (current Admissions) has been with facility for a week and is still learning. V48 is assisting with PASRRs but has not contacted the state-designated authority to do the assessment until date of the survey. Facility's 'Pre-admission Screening and Resident Review (PASRR)' policy documents in part: It is the Policy of this facility to: 1. Comply with Federal, State and the appointed screening agency, [Company Name], in standards addressing the PASRR assessment/screening process. 2. Request full and complete PASRR materials (Level 1 and 2) for each referral source prior to or soon following admission. 3. Review the PASRR document to help assess/ascertain what type of problems, needs and issues need to be addressed to help the resident function at his/her maximum level of well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Number of residents sampled: 35Number of residents cited: 1 Based on interviews and record reviews, the facility failed to follow physician orders and perform daily wound care for R177 and failed to ensure accurate Treatment Administration Records (TAR) for R177 for one out of a total sample of 35 residents.Findings include: R177's ‘admission Record' documents in part diagnosis information of acquired absence of left leg below knee, encounter for orthopedic aftercare following surgical amputation, encounter for change or removal of surgical wound dressing, type 1 diabetes mellitus, and type 2 diabetes mellitus. R177's ‘Care Plan Report' documents in part a focus that R177 has an amputation of left below knee amputation (BKA). Interventions include to do dressing change per doctor's order. R177's ‘Order Summary Report' documents in part wound care orders for left below knee amputation site. Staff are to cleanse with normal saline solution, pat dry, apply nonadherent dressing pad, loose gauze bandage, and compression/elastic bandage every day shift and as needed for wound care. The order date and start date is 8/02/2025. On 8/05/2025 at 10:50 AM, R177 stated new left below knee amputee. admitted to the facility on Friday (8/01/2025) for wound care and other skilled services. R177 stated the nurses did not change the dressing to the site over the weekend. R177 was concerned stating that being a diabetic makes it difficult for wounds to heal and wanted wounds taken care of as ordered. R177 stated facility didn't do wound care to left BKA until Monday (8/04/2025). R177's ‘Treatment Administration Record (TAR)' documents in part that V26 (Wound Care Nurse) checked off wound care administered to left below knee amputation site on Saturday (8/02/2025). It has no charting for 8/03/2025 wound care to left below knee amputation site. On 8/05/2025 at 3:09 PM, V26 stated [V26] did not do R177's BKA wound care on Saturday despite what R177's TAR reads. V26 stated R177 said the BKA dressing was supposed to be changed every other day. Since R177 admitted from the hospital on Friday night, V26 did not do the dressing change Saturday. Surveyor asked if V26 verified R177's wound care orders with the hospital or R177's admitting physician. V26 stated no. Surveyor went over R177's current wound care orders with V26. V26 stated V27 (Wound Care Coordinator) placed the orders in. On 8/05/2025 at 3:26 PM, V27 stated that staff called V27 on 8/02/2025 about R177's wounds. V27 audited R177's chart remotely from home and did not see any initial/admitting wound care orders. V27 coordinated with the physician and placed the wound care orders. V27 stated V26 was supposed to do the wound dressing on Saturday as ordered. V27 also stated that V15 (Wound Care Nurse) was scheduled to do R177's wound care on Sunday but is not sure why V15 did not do it. Facility's ‘Physician Orders-(Following Physician Orders)' policy documents in part: It is the policy of the facility to follow the orders of the physician. At the time of admission, the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. Facility's ‘Wound Cleansing and Dressings' policy documents in part: It is the policy of this facility to cleanse all wounds to clear exudates, bacterial contamination, and debris from the wound bed. Optimal wound healing cannot proceed until inflammation producing substances are removed from the wound bed. Wound cleansing is completed as indicated in the physician's order by licensed nurse. It is the policy of this facility to perform wound dressing changes as ordered by the physician using clean technique on all chronic or contaminated wounds. Apply new dressing after cleansing the wound per physician order.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review the facility failed ensure hazardous items were stored securely for one R12 resident reviewed for safety in a sample of 35.Findings Include:R12 has diagnosis not limited to Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, with Psychotic Disturbance, Dependence on Wheelchair, Disorder of Adult Personality and Behavior, Mood [Affective] Disorder, Cerebral Ischemia, Paranoid Personality Disorder and Altered Mental Status. R12's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 99 indicating resident is rarely/never understood. Section GG - Functional Abilities document in part: Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving (Dependent) Helper does all of the effort. R12's Care Plan Document in part: Dressing/Grooming: Focus: I have a Self-Care Deficit with impaired Dressing and Grooming abilities and I would benefit from participation in a Dressing/Grooming Restorative Nursing Program as evidenced by the following risk factors and potential contributing Diagnosis: General Weakness and/or fatigue, Impaired Strength and Endurance, Requires Limited Assist with Grooming. The Restorative Aides and/or Certified Nursing Assistant will provide my established Dressing and Grooming assistance per the goal for my Dressing and Grooming Restorative Program 6-7 days weekly. Focus: ADL'S (Activities of Daily Living): I have a Self-Care Deficit and I require assistance with ADLs to maintain the highest possible level of functioning.On 08/05/25 at 11:51 AM R12 Two disposable razors were observed in two of three plastic cups located on R12's overbed table. R12 said I usually shave myself; I have disposables. I had three disposable razors and theses are only two razors that I used. They gave the razors to me to be used. It is a disposable razor, and I need to shave. No one has ever done it, I shave myself.On 08/07/25 at 11:40 V36 (Regional Nurse Consultant) stated I don't think we have a shaving assessment for R12. Restorative may have an assessment for R12.On 08/07/25 at 12:25 PM V2 (Director of Nursing) stated disposable razors, are kept in the storage room. We have the certified nurse assistant of restorative aide assist the resident with shaving and we throw the disposable razors out afterwards. The disposable razors get dull and can cause cuts and scrapes. The residents should be assessed if they can use the razor. I have restorative on each floor they or the certified nurse assistant shave shaves the residents. I am not sure if R12 has a shaving assessment, I will have to look to see what his assessment is. If the disposable razors are left at the bedside, R12 could try to use the razors and cut himself.On 08/07/25 at 12:35 PM V36 (Regional Nurse Consultant) stated they did reassess R12 on the MDS (Minimum Data Set) Section GG (Functional Abilities). R12 is able to shave himself if he has a mirror. We don't have a shaving assessment for R12. R12 should not have razors at the bedside from a safety standpoint.On 08/07/25 at 01:00 PM V43 (licensed Practical Nurse/Restorative Nurse) stated there are no assessments for shaving. We provide the equipment and supervise when the residents are shaving. The razors are thrown in the sharp's container. I never assessed R12 myself and R12 is able to move the upper extremity. We will have to assess if R12 can shave himself. I am not aware if the residents can have the razors at the bedside. R12's certified nurse assistant should supervise him. The residents should not have razors at the bedside unless approved by the doctor or they have an order. If razors are left at the bedside there is a potential that R12 can cut himself.On 08/07/25 at 01:12 PM V43 (licensed Practical Nurse/Restorative Nurse) stated I removed the two razors and social service is educating R12.On 08/07/25 at 04:53 PM V1 (Administrator) provided a document titled Education Record dated 08/05/25 Razor Disposal Policy.Policy:Titled Guidelines for Handling Contaminated Sharps dated 08/18/23 document in part: Purpose: As part of the facility's Infection Prevention and Control Program -it is the intent of the facility to ensure that sharps -defined as objects that can penetrate a worker's skin, such as needles, razor blades or other potentially infectious materials. Contaminated Sharps: Prompt Disposal: Contaminated sharps must be disposed of in a sharp's container - immediately or as soon as feasible after use.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F695Based on observations, interviews, and record reviews, the facility failed to: (A) Maintain proper storage of oxygen nasal cannula tubing for 3 (R39, R52, and R107). (C) Ensure nebulizer tubing and mask were changed for 1 (R62) resident.These failures affected four (R39, R52, R62, and R107) out of four residents reviewed for respiratory care in a sample of 35.Findings Include: R39's Minimum Data Set (MDS) dated [DATE], Brief Interview Score indicates he is cognitively impaired. R39 Physician Order Sheet (POS) dated 8/5/25 shows an active diagnosis which are not limited to: chronic obstructive pulmonary disease, dependence on supplemental oxygen, other fatigue, and acute respiratory failure with hypoxia. R39 has an active order for oxygen at 2 Liters per minute/lpm, via nasal cannula every shift for Shortness of Breath (SOB)R52's MDS dated [DATE], Brief Interview Score (14) indicates she is cognitively intact. R52's POS dated 8/7/25 shows an active diagnosis of chronic obstructive pulmonary disease (COPD), hypertensive heart disease with heart failure, unspecified asthma with status asthmaticus, and respiratory failure with hypercapnia. R52 has an active order for oxygen at 2-3 lpm, per nasal cannula as needed related for hypoxia. R62's MDS dated [DATE], Brief Interview Score (05) indicates she is cognitively impaired. R62 POS dated 8/5/25 shows an active diagnosis of cardiac murmur, asthma and cough. R62 has an active order for ipratropium-albuterol inhalation solution0.5-2.5, 1 vial inhale orally every six hours as needed for wheezing. R62's medication Administration Record/MAR shows nebulizer treatment was given on 8/5/25 at 6am.R107's MDS dated [DATE], Brief Interview Score (14) indicates she is cognitively intact. R107 POS dated 8/5/25 shows an active diagnosis of chronic obstructive pulmonary disease (COPD), transient cerebral ischemic attack, and epilepsy R107 has an active order for oxygen at 2-3 lpm, per nasal cannula as needed for SOB.On 8/5/25 at 10:06 AM, surveyor and V17 (Registered Nurse/RN) entered R62's room, observed nebulizer tubing/mask not changed. She stated that tubing should be changed every weekly on Sundays to prevent infection, but the last time the tubing/mask was changed was 7/21/25. On 8/5/25 at 11:18 AM, R39 received up in bed, his portable oxygen nasal cannula tubing was hanging on his wheelchair when not in use. V10 (Registered Nurse/RN) stated that the nasal cannula should be stored in a bag when not in use.On 8/5/25 at 11:23 AM, R107 observed in bedroom, up in her wheelchair, stated she has been in the facility for ten years, she has no bag for her oxygen tubing, and she has used her oxygen today. Oxygen nasal cannula tubing hanging on the oxygen concentrator tank, not in a plastic bag when not in use. On 8/6/25 at 10:08 AM, V28 (Licensed Practical Nurse/LPN) stated the nasal cannula should be kept in a bag when not in use.On 8/6/25 at 9:53 AM, surveyor and V28 entered R52's room, observed oxygen nasal cannula tubing hanging on the oxygen concentrator tank. V25 stated that the oxygen nasal cannula tubing, should be stored in a bag when not in use to prevent germs which can cause respiratory infection, and she will discard the tubing now.On 8/7/25 at 11:12 AM, V2 (Director of Nursing/DON) stated she expects that the nebulizer tubing/mask will be changed every Sunday, and oxygen nasal cannula tubing will be kept in a plastic bag when not in use to prevent infection.Facility policy titled Oxygen Administration documents in part: Tubing, humidifier bottles and filters will be changed, cleaned and maintained no less than weekly and as needed (PRN).The facility could not provide any policy on storage of oxygen nasal cannula tubing when not in use.

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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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F725Based on observation, interview and record review, the facility failed to ensure sufficient staff to administer medications as ordered by physician and attend to resident's needs or care in a timely manner. These failures could potentially affect all residents residing in the facility. The findings include:On 8/5/25 At 10:50AM Observed R34 up and about, ambulatory with steady gait, alert and oriented x 3, verbally responsive. Stated medication does not come on time depending on the nurse. R34 said on 8/2/25 (Saturday) there was only 1 nurse working and the nurse on her side came late around 12noon. She said she got her morning medications around 12noon, and it is supposed to be given around 9am. Stated medications were given late because of short staff. MDS (Minimum Data Set) dated 6/5/2025 showed R34's cognition was intact. R34's physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Furosemide, Magnesium, Thiamine, Cyanocobalamin, Folic Acid, Aspirin, Potassium Chloride, Divalproex, Gabapentin, Amlodipine, Metoprolol scheduled on 8/2/25 with physician ordered time at 9AM were administered at 11:34AM, 11:39AM and 11:40AM. R34's care plan dated 5/30/25 showed interventions not limited to Administer medication per physician order. On 8/5/25 at 11:26AM R46 observed sitting on wheelchair, alert and oriented x 3, verbally responsive, very upset stated that he did not get his 9am medications yet. He said he has been having pain on right leg and scored pain as 8/10. R46 said he does not need PRN (as needed) pain medication if he gets his scheduled medications around 9am. Stated he has been residing in the facility for almost 5 years and at times, his medications are given late depending on the nurse working and at times short of staff. R46 said he has been waiting for his medications for couple of hours and no staff came. On 8/5/25 At 11:33AM Observed V18 (Licensed Practical Nurse / LPN) prepared medications and prepared the following medications: Cephalexin 500mg 1 capsule, Diclofenac 50mg 1 tablet, Eliquis 5mg 1 tablet, Lisinopril 10mg 1 tablet, Metoprolol 50mg 1tablet, Magnesium oxide 400mg 1 tablet, Furosemide 40mg 1 tablet, Fish oil 1 capsule, Folic acid 1 tablet. MDS dated [DATE] showed R46's cognition was intact. R46's POS and MAR (Medication Administration record dated 8/5/25 showed medications not limited to Cephalexin, Diclofenac, Eliquis, Lisinopril, Metoprolol, Magnesium oxide, Furosemide, Fish oil, Folic acid with physician ordered time at 9AM. On 8/06/2025 10:08 AM Surveyor conducted resident council meeting attended by 6 residents including R77 and R156 and stated on 8/2/25 their medications were given late due to short of staff. They waited for 2-3 hours to get their scheduled medications. R77 said if medication is given late there is shorter time gap for the next dose of medication. R156 stated he had witnessed that his roommates have been calling for help to be changed and needed to wait for more than an hour.R77's physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Furosemide, Spironolactone, Zinc oxide, Fluticasone, Jardiance, Methocarbamol, Spiriva inhaler, Allopurinol, Metformin, Gabapentin, Amlodipine scheduled on 8/2/25 with physician ordered time at 9AM were administered at 12:37PM. R77's care plan dated 5/29/25 showed intervention not limited to Administer medication as ordered. MDS dated [DATE] showed R77's was cognitively intact. R156's physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Pregabalin, Vitamin C, Multivitamin, Lidocaine, Baclofen, Docusate Sodium, Polyethylene Glycol scheduled on 8/2/25 with physician ordered time at 9AM were administered at 11:29AM and 11:30AM. R156's care plan dated 11/7/23 showed intervention not limited to Administer medication as ordered.MDS dated [DATE] showed R156's cognition was intact.On 8/7/25 at 10:55am Observed R70 resting in bed, alert and oriented x 3, verbally responsive. Stated there are times that he needed to wait for at least an hour to be changed. He said at one point he waited for 3hours to be changed, and he missed his therapy session because he was late to go down. R70 said care is not done in a timely manner because of short staffing. MDS dated [DATE] showed R70's cognition was intact. He needed Partial / moderate assistance with toileting and personal hygiene, shower / bathe self, upper and lower body dressing. MDS showed R70 was Occasionally incontinent of bowel and bladder.At 8/7/25 at 11:01AM Observed R163 resting in bed on moderate high back rest, alert and oriented x 3, verbally responsive. Stated most of the time, has been calling for help but nobody would respond to call light to attend to his needs in a timely manner. Stated he needed to wait at least an hour to an hour and half to be changed due to short of staff. MDS dated [DATE] showed R163's cognition was intact. He needed Partial / moderate assistance with oral hygiene; Dependent with toileting hygiene, shower / bathe self, lower body dressing, chair / bed transfer;

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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** F755Based on observation, interview and record review, the facility failed to follow their policies and procedures to ensure resident received their medications according to the physician's order for 6 (R25, R34, R46, R77, R107 and R156) residents reviewed for medication administration in a sample of 35.The findings include: R34’s admission record showed admit date on 5/29/2025 with diagnoses not limited to Other seizures, Hypertensive heart disease without heart failure, Polyneuropathy, Depression, Idiopathic peripheral, Autonomic neuropathy. MDS (Minimum Data Set) dated 6/5/2025 showed R34’s cognition was intact. R46’s admission record showed admit date on 4/3/2020 with diagnoses not limited to Unilateral primary osteoarthritis right hip, Chronic obstructive pulmonary disease, Chronic pulmonary edema, Heart failure, Paroxysmal atrial fibrillation, Unspecified atrial flutter, Hypertensive heart disease with heart failure, Type 2 diabetes mellitus, Venous insufficiency (chronic) (peripheral), Iron deficiency anemia, Hyperlipidemia. MDS dated [DATE] showed R46’s cognition was intact. R77’s admission record showed admit date on 5/26/2021 with diagnoses not limited to Chronic obstructive pulmonary disease, Acute and chronic respiratory failure with hypercapnia, Chronic obstructive pulmonary disease with (acute) exacerbation, Chronic diastolic (congestive) heart failure, Hypertensive heart disease with heart failure , Venous insufficiency (chronic) (peripheral), Type 2 diabetes mellitus, Other unilateral secondary osteoarthritis of hip, Gout. MDS dated [DATE] showed R77’s was cognitively intact. R156’s admission record showed admit date on 12/21/2023 with diagnoses not limited to Paraplegia, Hyperlipidemia, Neuromuscular dysfunction of bladder, Polyneuropathy, Acquired absence of kidney. MDS dated [DATE] showed R156’s cognition was intact. On 8/5/25 At 10:50AM Observed R34 up and about, ambulatory with steady gait, alert and oriented x 3, verbally responsive. Stated medication does not come on time depending on the nurse. R34 said on 8/2/25 (Saturday) there was only 1 nurse working and the nurse on her side came late around 12noon. She said she got her morning medications around 12noon, and it is supposed to be given around 9am. Stated medications were given late because of short staff. R34’s physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Furosemide, Magnesium, Thiamine, Cyanocobalamin, Folic Acid, Aspirin, Potassium Chloride, Divalproex, Gabapentin, Amlodipine, Metoprolol scheduled on 8/2/25 with physician ordered time at 9AM were administered at 11:34AM, 11:39AM and 11:40AM. R34’s care plan dated 5/30/25 showed interventions not limited to Administer medication per physician order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/25 at 11:26AM R46 observed sitting on wheelchair, alert and oriented x 3, verbally responsive, very upset stated that he did not get his 9am medications yet. He said he has been having pain on right leg and scored pain as 8/10. R46 said he does not need PRN (as needed) pain medication if he gets his scheduled medications around 9am. Stated he has been residing in the facility for almost 5 years and at times, his medications are given late depending on the nurse working. R46 said he has been waiting for his medications for couple of hours and no staff came. On 8/5/25 At 11:28AM Surveyor asked V18 (Licensed Practical Nurse / LPN) regarding R46 scheduled medications and stated she came in late around 10am today, it was V2 (DON) and V15 (LPN) covered her assignment with V11 (RN orientee) and prepared R46’s medications. She said V11 attempted to give medications to R46 but did not take it stating there were medications missing. V18 attempted to administer previously prepared medications to R46 and said could not see his blood thinner medication which is pink and oval shape and did not see the Glucosamine. On 8/5/25 At 11:33AM V18 discarded previously prepared medications and prepared the following medications: Cephalexin 500mg 1 capsule, Diclofenac 50mg 1 tablet, Eliquis 5mg 1 tablet, Lisinopril 10mg 1 tablet, Metoprolol 50mg 1tablet, Magnesium oxide 400mg 1 tablet, Furosemide 40mg 1 tablet, Fish oil 1 capsule, Folic acid 1 tablet. V18 said Glucosamine tablet was not available. She said she will order it to the pharmacy. V18 administer prepared medications and R46 said “where is my Glucosamine?” V18 responded it was not available and was ordered already. R46 took prepared medications by mouth. R46’s POS and MAR (Medication Administration record dated 8/5/25 showed medications not limited to Cephalexin, Diclofenac, Eliquis, Lisinopril, Metoprolol, Magnesium oxide, Furosemide, Fish oil, Folic acid with physician ordered time at 9AM. On 8/06/2025 10:08 AM Surveyor conducted resident council meeting attended by 6 residents including R77 and R156 and stated on 8/2/25 their medications were given late. They waited for 2-3 hours to get their scheduled medications. R77 said if medication is given late there is shorter time gap for the next dose of medication. R77’s physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Furosemide, Spironolactone, Zinc oxide, Fluticasone, Jardiance, Methocarbamol, Spiriva inhaler, Allopurinol, Metformin, Gabapentin, Amlodipine scheduled on 8/2/25 with physician ordered time at 9AM were administered at 12:37PM. R77’s care plan dated 5/29/25 showed intervention not limited to Administer medication as ordered. R156’s physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Pregabalin, Vitamin C, Multivitamin, Lidocaine, Baclofen, Docusate Sodium, Polyethylene Glycol scheduled on 8/2/25 with physician ordered time at 9AM were administered at 11:29AM and 11:30AM. R156’s care plan dated 11/7/23 showed intervention not limited to Administer medication as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/25 at 11:49AM V2 (Director of Nursing / DON) stated nurses are expected to administer Medications to residents according to physician order. Should follow 5R’s (right route, right resident, right time, right frequency, right dose) in giving medications. V2 said nurses should give meds 60minutes before and after physician ordered time. She said If the order time is at 9am, nurse is expected to give medication between 8am to 10am. If medication was given at 11:30am, it is considered late and not following physician ordered time. V2 said if blood pressure, blood sugar, pain medication was not given according to physician ordered time could potentially affect blood pressure, blood sugar or aggravate pain. Facility’s LPN’s and RN’s job description (undated) showed in part: Prepares and administers medications as ordered by the physician. Facility’s medication administration policy (undated) showed in part: To ensure that resident medications are administered in a timely manner. Unless otherwise specified by the physician, medications will be administered within 60minutes before and after the facility’s dosing schedule. Licensed professional nurses administer medications according to times documented on the medication administration record. Medication administration pass may begin sixty minutes before the scheduled times of administration but may not exceed to sixty minutes after the scheduled times of administration. Findings Include: R25’s Minimum Data Set (MDS) dated [DATE] shows he is cognitively intact. R25's Electronic Medical Record (EMR) revealed he was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: end stage renal disease, dependence on renal dialysis, other age-related cataract, unspecified atrial fibrillation, type2 diabetes mellitus with foot ulcer, dry eye syndrome, anemia, and hypertensive heart disease without heart failure. R107’s Minimum Data Set (MDS) dated [DATE] shows she is cognitively intact. R107's Electronic Medical Record (EMR) revealed he was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: anemia in chronic kidney disease, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertension, chronic obstructive pulmonary disease, and epilepsy. On 8/5/25 at 10:35 AM, R25 in bed, stated that he has been in the facility for about eight months. He does not receive his scheduled medication at times and sometimes he received his medication late, and he did not receive some of his medications last Saturday 8/2/25. On 8/5/25 at 11:23 AM, R107 up in wheelchair, stated that she has been in the facility for ten years, she receives her medication late at times, and she did not receive most of her medications on Saturday 8/2/25. On 8/7/25 at 10:03 AM, V44 (Registered Nurse/RN) stated that she has been in the facility since 2016, Medication Administration Record (MAR) should be signed once the medication is given, and if MAR is not signed, then the medication is not given. She worked 3pm-11pm shift on 8/2/25 with R25 without signing the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/25 at 10:18 AM, V42 (Licensed Practical Nurse/LPN) stated that she has been in the facility for twenty-seven years, and she worked 7am-3pm shift on 8/2/25 with R107. Nurses should administer medication as ordered by the physician, sign the MAR, and if MAR is not signed, the medication is not given, and that will affect the resident’ well-being. On 8/7/25 at 11:12 AM, V2 (Director of Nursing/DON) stated that she has been in the facility for three months, it is her expectation that nurses will administer medication has scheduled by the physician, and sign MAR. When medications are not administered to resident as ordered it could lead to increase sickness and distress. She ensures that nurses sign the MAR once the medication is given, and no resident reported to her that medication was not administered as scheduled. Documents reviewed for this complaint are not limited to the following. R25’s Medication Administration Record (MAR) shows that fourteen medications were not signed/administered to him on 8/2/25 during the 3pm-11pm shift. R107’s MAR shows that fifteen medications were not signed/administered to her on 8/2/25 during 7pm-3pm shift. R25, and R107’s Face Sheet, POS, MAR, and Section C of MDS. Policy and Procedure titled, “Medication Administration” documents in part: Medication administration record (MAR) will be signed after for each medication administered to the resident. Resident Council Meeting Minutes from 6/24/24 to 7/29/25. Grievance/Concern Forms from 8/2/24 to 12/12/24, and 5/1/25 to 8/4/25.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Number of residents sampled: 35Number of residents cited: 1 Based on interviews and record reviews, the facility failed to follow provider orders and provide radiology services to one resident (R78) out of a total sample of 35 residents.Findings include: On 8/05/2025 at 11:20 AM, R78 stated experiencing coughing spells sometime last month. A provider evaluated R78 and ordered a chest x-ray. R78 stated facility never did it. R78's 7/14/2025 11:15 AM progress note by V32 (Nurse Practitioner) documents in part that R78 complained of chronic cough. As part of treatment plan, V32 ordered a chest x-ray. R78's 'Order Audit Report' documents in part that V30 (Nurse) entered the two-view chest x-ray on 7/16/2025 (two days later) at 4:47 PM on behalf of V32. On 08/06/2025 at approximately 9:30 AM, V1 (Administrator) informed surveyor that there was no chest x-ray results for R78. On 08/06/2025 at 12:22 PM, V34 (Nurse) stated the nurse practitioners or doctors will communicate to the nurses if there are new orders. The providers will put the orders in the computer unless it's a verbal or telephone order. The nurses will then have to acknowledge and confirm the order in the electronic medical record. V34 stated if the nurse doesn't see the order then they can call the provider and verify whether they still want the order. V35 (Nurse) also stated that they can follow-up with V2 (Director of Nursing) or V3 (Assistant Director of Nursing) to help verify the order. On 8/06/2025 at 3:26 PM, V30 (Nurse) stated following up with V32 (Nurse Practitioner) regarding the chest x-ray on 7/16/2025. Per V30, V32 gave a verbal order to another nurse on 7/14/2025. V30 stated the nurse should have entered it in the electronic medical record but must have forgotten to do it. V32 instructed V30 to continue with the order for chest x-ray for cough and shortness of breath so V30 entered it in the computer. V30 stated calling the contracted radiology company twice to do the chest x-ray but they never did it during V30's shift so V30 endorsed it to the oncoming shift to follow-up. R78's progress note dated 7/18/2025 at 5:30 AM documents in part that R78 continued to complain of cough and was still due for the chest x-ray. R78 called emergency services for hospital evaluation. Facility's 'Guidelines for Diagnostic Services' documents in part: It is the policy of this facility to ensure that laboratory, radiology, and other diagnostic services meet the needs of residents, that results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, and treatment, and that the facility has established policies and procedures, and is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource. The facility will provide or obtain radiology and other diagnostic services to meet the needs of its residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to discard out-dated food items, store food items away from cleaning solution, and ensure food items were distributed and served to residents under sanitary conditions. This has the potential to affect 168 residents that receive nutrition from the kitchen. Surveyor 40061's findings include: On 8/05/2025 at 9:18 AM, surveyor conducted an initial kitchen tour with V7 (Dietary Manager). In the dry storage room, there was an opened box of powdered non-dairy creamer packets. One of the labels in the box documented in part to best use by 6/22/2025. V7 stated there was no expiration date on the box. V7 did not know if powdered creamer expired and stated it was better to toss it since V7 did not know if the product was still good. At 9:29 AM, during the initial kitchen tour, there was a large box of bananas on the bottom shelf in one of the prep stations in the back of the kitchen. Next to the box was a sanitation bucket. V7 stated there was cleaning solution in the bucket. On 8/06/2025 at 2:10 PM, V7 provided 'Diet Tally' of all residents in the facility. Four residents do not receive nutrition by mouth (no prepared food from the kitchen). Facility's 'Food Storage (Dry, Refrigerated and Frozen)' policy documents in part that food shall not be stored where chemicals are stored. All out-dated goods will be discarded the day after expiration. -- -- -- -- -- The findings include: On 8/5/25 At 12:32PM Dining observation conducted on 2nd floor dining room. Observed V20 (Certified Nursing Assistant / CNA), V21 (CNA), V22 (RESTORATIVE AIDE/CNA), V23 (CNA) passing / distributing lunch trays from the dining room to residents' rooms with mandarin oranges in dessert bowl and juice in plastic cup not covered and exposed to contaminants. On 8/7/25 at 10:06AM V7 (Dietary Manager) and V8 (Regional Director of Operations for Archway management) stated they are contracted in the facility. V8 said staff in the unit should bring meal cart outside of resident's rooms to distribute or pass meal tray, so all food items are covered and not exposed to contaminants. V7 and V8 said if staff is passing meal trays from the dining room to resident's rooms, all food items such as mandarin oranges in dessert bowl or juice in cup should be covered for infection control to prevent contamination. On 8/7/25 at 11:49AM V2 (Director of Nursing / DON) said staff is expected to distribute or pass meal trays in sanitary condition, all food items should be covered and not exposed to contaminants for infection control to prevent contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to practice appropriate infection prevention and control measures by staff not wearing appropriate Personal Protective Equipment (PPE) while providing care to a resident (R167) on Enhanced Barrier Precautions (EBP) and failed to ensure that a resident (R177) with wounds was on Enhanced Barrier Precautions (EBP). These failures have the potential to affect R177 and all 62 residents residing on the 3rd floor. Infection Control Findings include: R177's 'admission Record' documents in part diagnosis information of acquired absence of left leg below knee, encounter for orthopedic aftercare following surgical amputation, and encounter for change or removal of surgical wound dressing. R177 admitted to the facility on [DATE]. R177's 'Order Summary Report' documents in part Enhanced Barrier Precautions for Wounds every shift. The order date and start date is 08/03/2025. On 8/05/2025 at 10:50 AM, R177 was in bed and had dressing to left below knee amputation. R177 stated new left below knee amputation surgical site and other wounds to right lower extremity that requires wound care from the facility. There was no Enhanced Barrier Precaution signage in R177's door or personal protective equipment. Facility did not put signage until the following day. Findings include: On 08/05/25 at 11:47 AM, observed V13 (Certified Nursing Assistant) performing incontinence care for R167. V13 was wearing a face mask and gloves. V13 was not wearing a gown. Observed adequate supply of PPE including gowns, gloves, masks hanging on the outside of R167's door next to signage for Enhanced Barrier Precautions. On 08/05/25 at 11:51 AM, V13 stated she was changing R167's incontinence brief because he was wet. V13 stated she has been working at the facility for approximately two months. V13 stated she sometimes wears a gown, but she always wears gloves and a mask. V13 stated she wears a gown if there is a sign on the resident's door for isolation. V13 went with surveyor to observe the EBP sign outside R167's door. V13 then stated based on that sign she should wear a gown. On 08/05/25 at 11:59 AM, V14 (Registered Nurse) stated staff are required to wear gloves, gown and mask when providing direct care to residents with any touch contact if the resident is on EPB. V14 stated the purpose of the staff wearing appropriate PPE is to contain infections and stop the spread of infection. V14 stated if a staff is changing a resident without wearing a gown there is the potential that urine and/or stool from the resident could get on the staff's clothing which could potentially spread to another resident. V14 stated that is why a gown should be worn over the staff's clothing. V14 stated R167 has wounds on his legs which have dressings on them which is why he is on EBP. V14 stated anyone coming in direct contact with R167 when giving care should be wearing mask, gloves, and gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/06/25 at 12:30 PM, V4 (Infection Control Preventionist/Licensed Practical Nurse) stated anyone on any kind of isolation should have signage posted outside the room to alert anyone going into the room what PPE should be worn and the type of precautions needed depending on the type of care being given. V4 stated the purpose of Enhanced Barrier Precautions are to help prevent the spread of infection in the facility. V4 stated EBP are used for residents with any type of openings from medical devises and for residents with wounds. V4 stated if a staff is going to have any direct contact with the resident on EBP with potential exposure to bodily fluids the staff are required to wear a gown and gloves. V4 stated it is important to have the EBP sign posted outside the room, so the staff/visitor is alerted to what they need to wear and do before entering the room. V4 stated if the sign is missing the staff and/or visitor will not know they should be performing hand hygiene before entering and upon exiting the room and/or wear gown and gloves during high contact resident care activities. V4 stated if the staff does not wear gown and gloves when providing incontinent care and changing a resident's incontinent brief, changing their clothing or when changing linens there is a potential risk of spreading infection. V4 stated it is her and/or nursing responsibility for posting the EBP signage outside the resident's door. On 08/06/25 at 12:40 PM, V4 stated R177 is on EBP for his wound and he was admitted to the facility over the weekend. V4 stated she got an order for EBP on Tuesday, 08/05/25 and put up the EBP signage 08/05/25. V4 stated R177 was admitted to the facility with the wound and therefore the EBP signage should have been posted outside his door on the day he was admitted to the facility. V4 stated the potential problem with the EBP sign not being posted on R177's door upon admission is that the staff did not know they should be following EBP guidelines and may not have been wearing a gown and gloves during direct contact with the resident until the EBP signage went up yesterday which could potentially lead to the spread of infection. On 08/07/25 at 11:40 AM, V27 (Wound Care Director/Registered Nurse) stated R167 has an open wound to his right ankle which was identified on 06/30/25 and a skin tear to his lower leg which is an opened wound. V27 stated R167 should be on EBP because he has opened wounds and that she wears a gown and gloves when treating R167's wounds. V27 stated anyone providing direct care that is not wearing a gown could potentially contaminate his wound which is an infection control concern. On 08/07/25 at 9:52 AM, V2 (Director of Nursing) stated if a resident is on EBP there should be signage outside the door to alert staff, so they are reminded to do hand hygiene before and after entering the room and to wear a gown and gloves when providing contact care activities such as changing bed linens and when providing incontinence care. V2 stated wearing appropriate PPE is important to keep the residents and the staff safe and decrease the spread of infection in the facility. V2 stated the potential problem with the staff not wearing a gown and gloves when giving care to a resident on EBP is that bodily fluids can get on the staff's uniform which can potentially cause the spread of infection. V2 stated the facility wants to make sure the staff are not walking around spreading anything. V2 stated on the units the Certified Nursing Assistants (CNAs) have designated assigned rooms however they are responsible for answering all call lights on the unit for all the residents and assist other CNA with providing care as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R167's diagnosis included but not limited to Anthropopathic Psoriasis, Hypertensive Heart Disease, Wernicke's Encephalopathy, Anxiety Disorder, Seizures, Alcoholic Cirrhosis of Liver Without Ascites, Unspecified Protein Calorie Malnutrition, Iron Deficiency Anemia, Alcohol Dependence Withdrawal, Unsteadiness on Feet, Lack of Coordination, Repeated Falls, Weakness, Abnormal Weight Loss, Depression, Disorder of Adult Personality and Behavior, Need For Assistance With Personal Care, Altered Mental Status. R167's Order Summary Report dated 08/07/25 documents in part Enhanced Barrier Precautions every shift with order date 08/05/25 and right anterior foot cleanse with normal saline solution, pat dry, paint with betadine, bordered dressing order date 06/20/25 and apply Gentamicin Sulfate External Ointment to right ankle topically every day shift for wound care. Cleanse with normal saline solution, pat dry, apply santyl/gentamicin calcium alginate, gentle foam or kerlix ordered date 06/30/25. R167's infection control care plan documents in part that facility did not include a focus for EBP until 08/05/25. It documents in part, R167 is on Enhanced Barrier Precaution for wounds and skin openings requiring a dressing with intervention to all right follow Enhanced Precaution guidelines when providing care and coming in direct contact with potentially infected material or devices that put blank (R167) at risk. Direct care activities include dressing, bathing showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting and incontinence care. Facility provided policy titled, Guidelines for Enhanced Barrier Precautions (EBP) which documents in part, Enhanced Barrier Precautions are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of MDROs (Multidrug-Resistant Organisms) in the form of blood or body fluids onto the hands and/or clothing of the rendering caregiver. Residents who are at high risk for acquiring or spreading MDROs include residents with wounds regardless of MDRO status. Examples of high contact resident care activities at which time EBP is to be practiced are: providing hygiene (Activities of Daily Living), changing linens, changing briefs/assisting with toileting. Ensure that proper signage is posted on the resident's room door instructing those who plan to enter the room to check first at the Nurses' Station for education/instruction. Facility provided copy of Enhanced Barrier Precaution sign from the U.S. Department of Health and Human Services Center for Disease Control and Prevention which documents in part, providers and staff must also wear gloves and a gown for the following high-contact resident care activities which include but are not limited to wound care: any skin opening requiring a dressing.