STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145372	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Joliet, The	306 North Larkin Avenue Joliet, IL 60435

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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. 46409 Based on observation, interview, and record review, the facility failed to assess a resident who was self-administering medication. This applies to 1 of 1 residents (R76) reviewed for self-medication administration in a sample of 30. The findings include: R76's face sheet showed she was admitted with diagnoses including gastrointestinal hemorrhage, chronic obstructive pulmonary disease, morbid obesity, type 2 diabetes mellitus, congestive heart failure, gout, and repeated falls. R76's POS (Physician Order Sheet) showed an order dated 12/19/23 for Hemorrhoidal Rectal Ointment 0. 25-14-74.9% with instructions to Insert 1 application rectally every 8 hours as needed for hemorrhoids. R76's MDS (Minimum Data Set), dated 1/6/25, showed R76 had severe cognitive impairment. On 2/4/25 at 1:21 PM, R76 had a tube of hemorrhoid cream on her bedside table. The tube showed it was a two-ounce tube of hemorrhoidal ointment with applicator, and the sticker showed it was opened January 19, 2025. R76 said she was running out of the cream and needed it to help her butt cheeks slide. R76 said she did not have hemorrhoids, but the facility does not give her a different kind of cream. On 2/5/25 at 4:01 PM, R76 still had the hemorrhoidal cream at bedside. R76 said she puts the cream in the fold between her butt cheeks so that it slides so she can sit. R76 said she could not sit without putting the cream on because it helps slide nicely. R76 said she needed the cream for lubrication. R76 said she never put the cream inside her rectum. R76 said she needed the cream and could not remember who gave her the cream. R76 said the cream did not last too long and she had only been using it for a few weeks. R76 said the tube of hemorrhoidal cream also came with a tool that would help put the cream inside her rectum, but she never put it inside the rectum. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 10:20 AM, V5 (LPN/Licensed Practical Nurse) said R76 can be forgetful at times. V5 said R76 did not have an order to have medications at bedside or self-administer them. V5 said R76 did have orders for hemorrhoid cream, and it should be used for hemorrhoids inside her rectum. V5 said if the order showed it should be used rectally, then it should be used in the rectum, not on the butt cheeks. On 2/6/25 at 10:23 AM, V6 (RN/Registered Nurse) said she was taking care of R76, and she did have an order for hemorrhoid cream to be inserted rectally every eight hours as needed. V6 said she had never put the medicine on for R76, and the last time R76 had the hemorrhoid cream applied was on 9/22/24. V6 said R76 could not put it on herself, and the medication should not be in her room, as she did not have orders to self-medicate or store medications at bedside. On 2/6/25 at 3:43 PM, V2 (DON/Director of Nursing) said hemorrhoid creams should not be left in the room and should not be used as a barrier cream. V2 said residents who had severe cognitive impairment should not have medications at the bedside. The facility's Self Administration of Medication Program policy, reviewed on 4/25/24, showed, The facility will allow the resident to self-administer drugs if the interdisciplinary team, has determined that this practice is safe. Nurse will complete a Self-Administration of Medication Assessment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46409 Based on observation, interview, and record review, the facility failed to place call lights within reach of residents. This applies to 3 of 3 residents (R114, R2, R44) reviewed for call lights in a sample of 30. The findings include: 1. On 2/4/25at 10:37 AM, R114 was lying in bed, and her call light was placed on the side dresser, out of reach of the resident. R114 said she was unable to use her left arm, and she would use the call light to call for help, if she could find it. R114 said if she could not find it, she would have to scream for help. On 2/6/25 at 3:43 PM, V2 (DON/Director of Nursing) said the call lights should be attached to the bed linen or wrapped around the side rail. R114's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and weakness. R114's care plan, dated 12/22/23, showed R114 is at low risk for falls due to weakness, limited mobility, decrease strength, physical limitation, low activity tolerance [related to] hemiplegia, with interventions including to Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. R114's Call Light Ability Screen, dated 12/18/23, showed Yes when asked if Resident is able to follow instructions on how to use call light, and also showed Resident is able to use the call light. 46003 2. R2's current MDS (Minimum Data Set) shows she is cognitively intact. R2's care plan states she is at risk for falls. Interventions include to provide her with a working reachable call light. On 02/04/25 at 01:51 PM, R2's call light was near her right shoulder. R2 stated she needed the call light placed closer to her hand where she can reach it as she is unable to maneuver to get the call light. On 02/07/25 at 01:33 PM, V2, DON (Director of Nursing), stated, The CNAs (Certified Nursing Assistants) should make sure the resident call light is in reach. The CNAs and Nurses can make sure it in reach of the resident. We want to make sure if they have a need or in trouble, they can alert the staff. 3. R44's current MDS (Minimum Data Set) shows she is cognitively intact. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R44's care plan states she has an ADL (Activities of Daily Living) self-care deficit and potential for falls due to decreased mobility. Interventions include be sure R44's call light is in reach and encourage resident to use it for assistance as needed. On 02/04/25 at 01:12 PM, R44's call button was wedged between the bed frame and right-side rail. R44 could not reach her call light. On 02/05/25 at 01:06 PM, R44's call button was wedged between the bed frame and right-side rail out of reach. R44 stated she could not reach her call light and would have to scream out for assistance. On 02/06/25 at 10:09 AM, R44's call button was wedged between the bed frame and right-side rail still out of her reach. R44 stated she could not reach her call light. The facility's Call Light Use policy, reviewed on 6/18/24, showed Facility aims to meet residents needs as timely as possible. Call light system is utilized to alert staff of residents' needs. Residents capable of using the call light appropriately will have their call light accessible at all times.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45906 Based on interview and record review, the facility failed to protect the residents' right to be free from verbal and mental abuse. This applies to 3 of 6 residents (R81, R13, R45) reviewed for abuse. The findings include: 1. R81's 10/25/2024 MDS (Minimum Data Set) showed he is moderately cognitively impaired. R81's Abuse care plan (initiated 4/29/2022 and revised 2/6/2025-during the survey) showed a problem focus as may be at risk for potential abuse [related to] behavior problem. An intervention (revised 10/17/2022) showed, If [R81] becomes increasingly agitated or upset, stop what you're doing, ensure [R81] is safe and politely leave the area . V11's (Certified Nursing Assistant/CNA) abuse allegation statement showed, On Friday evening 01/10/2025 [V33] I overheard talking to [R81] disrespectfully. The nurse hollered stop that and then told resident to shut up! Loudly. The facility's Final Report for R81's abuse allegation showed, On 01/10/2025, [V11] alleged that she felt that the facility nurse was verbally discourteous to resident. The facility nurse suspended pending investigation. The abuse investigation is ongoing On 2/6/2025 at 9:06 AM, V11, CNA (Certified Nursing Assistant), stated she remembered the incident between R81 and V33, LPN (Licensed Practical Nurse), on January 10th. V11 stated she heard V33 in R81's room and holler at him to Stop that and Shut up! when V33 went in his room to pass medication. V11 stated she did not see the interaction but overheard it because V33's voice was raised. V11 stated she didn't think anyone else was around to hear it. On 2/6/2025 at 1:25 PM, V1 (Administrator/Abuse Coordinator) verified there was no evidence R81 was ever interviewed. V1 stated R81 is deaf, but he can speak. V1 stated she personally interviewed R81 four days after the staff member reported the abuse allegation, but she did not write any of it down. V1 stated the statements included in the abuse investigation [which include a second statement by V11, and statements by V13 (CNA), V12 (Nurse), and V40 (Social Services)] were part of the Human Resources investigation concerning V33's remarks about V12 and V33's behavior, and not part of the resident abuse allegation against V33 for the way she spoke to R81. V1 also verified there was no written statement or interview from V33 regarding her side of the abuse allegation. The Report ended with Patient is legally deaf when asked if [R81] heard or thought the nurse in question was rude to him, he responded no . the facility cannot substantiate mental abuse occurred. 2. R13's MDS 12/18/2024 showed his cognition is intact. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/2024 at 10:05 AM, R13 stated a week before Christmas, he was sitting on the side of his bed emptying his own colostomy bag and V33 (LPN) entered his room and started to yell and criticize his toileting habits. R13 stated he was angered by the experience. R13 stated V33 did not listen to him or his reasons or explanations. On 2/7/2024, V1 (Administrator/Abuse Coordinator) provided R13's undated handwritten statement regarding his abuse allegation against V33, naming her directly. R13 wrote that his three interactions with her have been contentious and he called them hostile visits. R13's statement showed .her only concern was regarding my toileting habits. She complained that what I was doing was repulsive to her, and that I should be getting up and going to the washroom instead of voiding next to the bed. R13's statement ended with I found her abrasive attitude and confrontational approach to be inappropriate and offensive. Such behavior has no place in this type of environment. On 2/6/25 at 4:14 PM, V1 said R13 is reliable and has never had any other concerns regarding facility staff. The facility's Final Report for R13's 2/6/2025 allegation showed R13 is alert and oriented. Under Disposition, the Report showed, Per staff interviews, the Nurse's approach and demeanor were not up to facility standards. The nurse did have similar negative interactions with other residents as well. The Report does not specify if abuse of R13 from V33 was substantiated or not. 3. R45's 1/5/2025 MDS (Minimum Data Set) showed her cognition is intact. On 2/6/2025 at 9:40 AM, R45 stated V33 had taken care of her in the past. R45 stated that she received a package from her sister a few months earlier that contained a pair of slippers and bottle of an over-the-counter medication. R45 stated V33 opened the package and saw the medication and blew up at me and got in my face. R45 stated V33 yelled at her and told her it was against the rules to have outside medication and dismissively waived me off and told me to go to my room. R45 stated she felt belittled and berated. R45 stated she never felt afraid, but she did feel humiliated. The facility's Abuse Policy and Procedure showed Policy Statement: Resident have the right to be free from abuse, neglect . The facility's Abuse Policy and Procedure (reviewed 9/5/2024) showed POLICY STATEMENT: Residents have the right to be free from abuse. The policy defined verbal abuse as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. The facility's Abuse Policy and Procedure defines mental abuse as including, but not limited to, humiliation, harassment, threats of punishment or deprivation, or offensive physical contact by .employee Mental Abuse is also the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. This includes, but is not limited to, harassing a resident; mocking, insulting, or ridiculing; yelling or hovering over a resident, with the intent to intimidate; threats of deprivation; and isolation. The facility prohibits abuse .of its residents, including verbal, mental, sexual or physical abuse . The facility has a no tolerance philosophy

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45906 Based on interview and record review, the facility failed to report an allegation of verbal abuse to the Illinois Department of Public Health (IDPH). This applies to 1 of 6 residents (R81) reviewed for abuse in the sample of 30. The findings include: The facility's 1/10/2025 Initial Report from R81's incident showed, On 1/10/25, A [Certified Nursing Assistant (CNA)- V11] alleged that she felt that the facility nurse was verbally discourteous to resident. The facility nurse suspended pending investigation. The abuse investigation is ongoing and the final will be sent into public health within 5 business days. V11's (CNA) statement from the investigation showed .the . nurse I overheard talking to [R81] disrespectfully. The nurse hollered stop that and told resident Shut up! Loudly. On 2/6/25 at 1:25 PM, V1 (Administrator) stated she thought the initial incident report and the final incident report were reported to IDPH, but neither of the reports were sent to IDPH, even though they would have been sent on two different days. V1 added as the Abuse Coordinator, it is her responsibility, and neither notification was sent. V1 confirmed the fax verifications provided did not include the IDPH fax number, the date, or the times to show they were actually sent. The Reporting & Response section of the facility's Abuse Policy and Procedure (reviewed 9/5/2024) showed . B. c. Initial Report to the State licensing agency, Illinois Department of Public Health, shall be made immediately after the resident has been assessed and the alleged perpetrator has been removed . Section E. showed Final Report & Follow up. Within five days after the report of the occurrence, a complete written report of the conclusion of the investigation, including the steps the facility has taken to respond to the allegation, will be sent to the Department of Public Health .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. 45906 Based on interview and record review, the facility failed to complete thorough abuse investigations to ensure abuse is recognized/identified and failed to maintain proof of thorough investigations. This has the potential to affect all residents in the facility. The findings include: The facility's 2/4/2025 CMS-671 Form showed 145 residents live in the facility. 1. On 2/6/2025 at 9:06 AM, V11, CNA (Certified Nursing Assistant), stated she remembered the incident between R81 and V33 LPN (Licensed Practical Nurse) on January 10th. V11 stated she heard V33 in R81's room and holler at him to Stop that and Shut up! when V33 went in his room to pass medication. V11 stated she did not see the interaction but overheard it because V33's voice was raised. V11 stated she didn't think anyone else was around to hear it. V11's abuse allegation statement showed, On Friday evening 01/10/2025 [V33] I overheard talking to [R81] disrespectfully. The nurse hollered stop that and then told resident to shut up! Loudly. The facility's Final Report for R81's abuse allegation showed, On 01/10/2025, [V11] alleged that she felt that the facility nurse was verbally discourteous to resident. The facility nurse suspended pending investigation. The abuse investigation is ongoing The Report ended with Patient is legally deaf when asked if [R81] heard or thought the nurse in question was rude to him, he responded no . the facility cannot substantiate mental abuse occurred. On 2/6/2025 at 1:25 PM, V1 (Administrator/Abuse Coordinator) verified there was no evidence R81 was ever interviewed. V1 stated R81 is deaf, but he can speak. V1 stated she personally interviewed R81 four days after the staff member reported the abuse allegation, but she did not write any of it down. (R81's 10/25/2024 MDS [Minimum Data Set] showed he is moderately cognitively impaired.) V1 also verified there was no written statement or interview from V33 regarding her side of the allegation. A second statement by V11 was included in the abuse investigation, as well as statements from V13 (CNA), V40 (Social Services), and V12 (Nurse), but V1 verified these statements were about a concurrent Human Resources incident regarding V33, rather than the abuse allegation investigation. V1 also provided seven pieces of paper with four questions on them, labeled Resident Interviews. The typed questions are: Do the nurses here take good care of you? Do you feel safe here in the facility? Do your CNAs assist with any issues? Are your medical needs met in a timely fashion? The papers are undated, no staff names are included to show who was asking the questions, and the papers do not show if any other questions were asked. On 2/6/2024 at 1:25 PM, V1 stated she thought that the Social Service Director and Social Services Assistant were the ones who asked the questions to the residents, and she stated she thought the interviews were completed on January 13th or 14th. V1 stated the residents interviewed were from throughout the building since V33 worked both floors. V1 stated she could not say if the residents were asked other questions more specific to the verbal abuse allegation made against V33. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R81's Final Report showed, Interviewed other residents and they do not have any issues with that nurse. Spoke with R1 and he states he feels safe to be in the facility. At this time, the facility cannot substantiate mental abuse occurred. Investigation concluded. On 2/4/25 at 12:22 PM, V2, DON (Director of Nursing), said V33 works full-time on the overnight shift at the facility. V2 also said V33 works throughout the facility, and she has been assigned to all residents. 2. On 2/7/2025 at 1:30 PM, all of the evidence for the facility's 11/23/2024 abuse investigation for R29 was requested. V1 (Administrator/Abuse Coordinator) provided the Initial and Final Reports that were sent to the Illinois Department of Public Health (IDPH), their corresponding fax confirmations, and written statements from V37 and V38 (CNAs- Certified Nursing Assistants). V1 verified there was no documentation of an interview with R29 or any residents. R29's Final Report showed R29 was alert and oriented, and the Report references speaking with [R29] again, and later .spoke with [R29] . The Report also showed Spoke with random patients and staff on the unit regarding CNA and no one had complaints at this time . On 2/7/2025 at 1:46 PM, V1 stated the allegation was reported by a nurse, but she did not know who. V1 also stated she spoke with R29, but nothing was documented. V1 verified that the entire investigation had been provided. 3.On 2/7/2024 at 1:30 PM, all of the evidence for the facility's 11/10/2024 abuse investigation for R252 was also requested. V1 provided the Initial and Final Reports sent to IDPH and their corresponding fax confirmations. V1 verified there was no other investigatory evidence aside from the Initial and Final Reports. V1 stated, There were no staff interviews- it was all verbal. V1 stated, Social Services asked residents if they felt safe. There were no resident interviews included in the investigation. V1 stated R252 was hospitalized , and she was unclear who reported the allegation. R252's Final Report showed, Investigation included staff interviews (nurses and CNAs) in which no one reported patient saying he felt unsafe in any way. Random residents were asked if they felt safe with the nursing staff and if they felt safe in the facility. They all stated that they feel safe and have no issues at this time At this time, we are not able to substantiate any abuse. The Investigation section of the facility's Abuse Policy and Procedure (reviewed 9/5/2024) showed, As soon as possible after an allegation of abuse, mistreatment the administrator or designee will initiate an investigation into the allegation which may include the following elements: interviewing all persons who may have knowledge .including all persons who reported the suspicion, allegation or incident; the alleged victim (if the victim is unable to be interviewed, this should be documented); the alleged perpetrator .; any witnesses or potential witnesses to the alleged occurrence or incident; any staff having contact with the resident during the period of the alleged incident; roommates, other residents, family or visitors .; a review of the medical record, including care plan; a review of all circumstances surrounding the incident . The policy continued, The investigation shall conclude whether the allegation of abuse, neglect, mistreatment .can likely be substantiated. Records of the investigation shall be maintained.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on observation, interview, and record review, the facility failed to provide assessment, treatment, services, devices, and care planning for residents with decreased ROM (Range of Motion). This applies to 5 of 5 residents (R114, R86, R46, R94, R99) reviewed for range of motion in a sample of 30. The findings include: 1. R114's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and weakness. R114's POS (Physician Order Sheet) showed an order to, [NAME] [Left] resting hand splint for contracture [management] daily, doff at [Night] and for hygiene, check skin integrity [Every] shift, starting 1/22/25. R114's MDS (Minimum Data Set), dated 12/20/24, showed R114 was cognitively intact. R114's MDS also showed R114 had an impairment on one side of the upper extremity. R114's care plan showed the resident has hemiplegia/hemiparesis [related to] stroke, but did not show the use of a resting hand splint. The care plan also showed Impaired mobility [Due to] hemiplegia/hemiparesis decreased ROM (Range of Motion) [related to] weakness, with a goal of [R114] will maintain ROM to BUE/BLE (Bilateral Upper Extremity/Bilateral Lower Extremity) through next review. On 2/4/25 at 10:37 AM, R114 was lying in her bed, and her left hand was closed into a fist. R114 said she had a stroke and was not able to move her left arm without the help of her right arm. R114 said she needed a splint/brace, and it was in the dresser. R114 said she was not able to put the splint on herself and would need help. On 2/4/25 at 12:48 PM, R114 did not have a splint on. On 2/5/25 at 1:14 PM, R114 did not have a splint on and said the staff did not put it on her. On 2/5/25 at 4:31, R114 still did not have a splint on her left arm. On 2/6/25 at 10:07 AM, R114 was in bed and did not have a brace on her left arm. On 2/6/25 at 2:31 PM, V10 (Director of Rehab) said R114 would use the right arm to lift the left arm. V10 said R114 would benefit from a splint and thought she had one. V10 said R114 should have the splint on her because it could cause a contracture if she did not use it. V10 said a splint was used if a resident did not have a lot of movement in their hand and it would help keep her hand open. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/25 at 2:22 PM, V9 (Restorative Aide) said R114's left side was impacted, and she was unable to open her hand. V9 said if the resident had an order for a splint, it should be applied. V9 said if the staff do not apply the splint, the hand could remain closed, get tighter, and could even hurt them if they try to put it on after waiting too long. 2. R86's face sheet shows he was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R86's POS shows an order, dated 1/19/22, for [Patient] to have resting hand splint to [Left] hand: don daily, doff at [Night] and during hygiene. R86's MDS, dated [DATE], shows R86 was cognitively intact. R86's care plan dated 11/27/23,, showed R86 will participate in splint/brace use to decrease contractures to left hand with interventions to Apply splint to left hand 6-7 days a week. On in the AM of at night as ordered. On 2/4/25 at 10:30 AM, R86 was lying in bed and there was a splint on R86's dresser table. When asked if R86 could open or wiggle his fingers, R86 was not able to open the last three fingers on his left hand. On 2/6/25 at 10:05 AM, R86 was sitting in his wheelchair, and he did not have his splint on his left arm. R86 said he needed help putting the splint on, and it had not been placed on him the whole day. On 2/6/25 at 2:19 PM, V9 (Restorative Aide) said the restorative staff put the splints on for all the residents in the facility, but she was made to work on the floor as a CNA (Certified Nursing Assistant), so was unable to apply the splints on the residents. V9 said no one was doing restorative therapy today. V9 said R86 needs to have a splint on every day and the CNA could apply it if restorative was unavailable. V9 said the splint should be applied when R86 wakes up. On 2/6/25 at 2:03 PM, V7 (CNA/Certified Nurse Assistant) said R86 was not able to open or close his hand, but she had not seen a brace. V7 said the restorative staff are the ones who apply the splints on the resident. On 2/6/25 at 2:11 PM, V8 (CNA) said she had not seen R86 wearing a splint recently. V8 said the CNAs can apply the splint on the residents. On 2/6/25 at 2:15 PM, V5 (LPN/Licensed Practical Nurse) said R86 would have a splint on the left hand and used to. V5 said restorative staff are the ones to put the splints on the residents. On 2/6/25 at 3:43 PM, V2 (DON/Director of Nursing) said the restorative CNAs should be putting the splints on the residents. The facility's Managing Residents with Impaired Physical Mobility policy, dated 3/16/24, showed Supporting devices such as splints and casts may be applied to stretch the tissues of the affected body part based on therapy/MD (Medical Director) recommendation. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	31327 3. R46's face sheet shows an admitted [DATE]. R46's face sheet shows diagnoses of metabolic encephalopathy, acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, and facial weakness following cerebral infarction. R46's MDS (Minimum Data Set), dated 12/11/24, shows a blank score for the BIMS (Brief Interview for Mental Status). R46 was triggered as moderately impaired under cognitive skills for daily decision making. R46 has impairment on both sides of his upper and lower extremities. R46's POS (Physician Order Sheet) shows the following orders: [NAME] right rest hand splint for contracture management daily, doff at NOC (Night Shift/Nocturnal) and for hygiene, check skin integrity every shift. Apply cervical collar when up in the wheelchair, may remove for feeding, hygiene, check for redness, discomfort, and pain. R46's care plan documents he has impaired cognitive function/dementia or impaired though processes related to dementia and history of stroke. R46 has limited physical mobility related to weakness, confusion, physical limitation to bilateral upper and lower extremities. R46 will remain free of complications related to immobility including contractures .Interventions: monitor/document/report as needed any signs or symptoms of immobility and contractures forming or worsening, provide gentle range of motion as tolerated with daily care and provide supportive care, assistance with mobility as needed. Document assistance as needed. R46 requires AROM (Active Range of Motion). Staff will provide assistance with AROM to upper and lower extremities. On 2/4/25 at 1:25 PM, R46 was sitting on his reclined chair in his room. R46's hands were contracted. He did not have his splints on. He also was not wearing his cervical collar. On 2/4/25 at 2:41 PM, R46 was laying in bed. He did not have his splints on. On 2/5/25 at 8:47 AM, R46 was sitting on his bed. He did not have his splints on. On 2/5/25 at 12:34 PM, R46 was sitting in his reclined chair. He did not have his cervical collar or splints on. On 2/5/25 at 2:01 PM, R46 was sleeping in his bed. He did not have splints on. On 2/6/25 at 9:46 AM, R46 was sitting in his reclined hair. He did not have his cervical collar or splints on. R46 was unable to answer surveyor's questions regarding his cervical collar, splints, and contracted hands. He was nonverbal, and just grumbled something when surveyor attempted to talk to him. On 2/5/25 at 12:43 PM, V2 (DON-Director of Nursing) stated, It is the responsibility of the restorative aides to apply the splints on the residents who have orders for them. I believe the nurses are supposed to be putting the cervical collars on those residents who have the orders as well. They should be following physician orders. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R94's face sheet shows an admitted [DATE], and diagnoses of aphasia following unspecified cerebrovascular disease, Wernicke's encephalopathy, and personal history of other mental and behavioral disorders. R94's POS (Physician Order Sheet) show no orders for R94 to have a splint or other restorative device. R94's MDS, dated [DATE], showed she is moderately impaired in cognition and she has impairment in both sides of her upper and lower extremities. R94's care plans show the following: (R94) has limited physical mobility due to weakness, decrease strength, and low activity tolerance. Restorative: PROM (Passive Range of Motion) to bilateral upper and lower extremities x 10 repetitions. (R94) will have PROM to all planes with staff daily, 6 to 7 days a week as tolerated. (R94) is at risk for pain related to adult failure to thrive, generalized pain. (R94) has a contracture to right hand/wrist. Apply palm protector/rolled towel to right hand daily. May remove splint for ADL (Activities for Daily Living)/hygiene tasks. (R94) has aphasia related to cerebral vascular accident. On 2/4/25 at 11:00 AM, R94 was lying bed. Her hands were contracted and she was not wearing a splint. Surveyor asked her if she was given a splint or towel rolled up to put between her fingers and palm. R94 stated, They don't really put anything between my hands. Surveyor asked if the restorative aides do any exercises with her. R94 responded, They don't really do any exercises because they can't open my fingers. On 2/5/25 at 10:02 AM, R94 was not wearing a splint. On 2/6/25 at 10:27 AM, R94 was not wearing a splint. On 2/6/25 at 11:23 AM, V15 (LPN-Licensed Practical Nurse/ Restorative Nurse stated, I'm new. I started in November/December 2024. They are supposed to wear splints and cervical collars as ordered. I don't have (R94)'s assessment. I didn't get a chance to review her chart. The restorative aides are supposed to be doing exercises with the residents. I don't know if they are documenting. Sometimes they have to work on the floor as CNA's (Certified Nursing Assistants). Today, they are working as CNA's. So, the residents are not getting any restorative exercises. On 2/6/25 at 2:05 PM, V15 came back to surveyor and said, I just did (R94's) assessment and I ordered her palm protectors. She wasn't wearing the palm protectors, because it was never ordered. I don't have any documentation showing (R46) and (R94) got ROM exercises. Facility's policy titled Managing Residents with Impaired Physical Mobility (3/16/24) shows, 1. Mobility assessment will be completed by a nurse upon admission, quarterly, and as necessary. Treatment guidelines for contractures will depend on the cause of the deformity. The following maybe utilized in general: b. Restorative program on assessment. c. Medical devise. Supportive devices such as splint and casts maybe applied to stretch the tissues of the affected body part based on therapy/MD (Medical Doctor) recommendation. B. Facility will develop a plan of care to assess the patient's level of functional mobility and ability to perform ADL's. c. Staff will encourage the patient to perform range of motion (ROM) exercises in all extremities as recommended by therapist or restorative nurse . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48526 5. R99's Face Sheet showed she was admitted to the facility on [DATE], with multiple diagnoses which included hemiplegia and hemiparesis, adult failure to thrive, transient ischemic attack and cerebral infarction. R99's Order Summary Report for 02/2025 showed a current order for, DON (Put On) left upper extremity form progressive hand splint for contracture management daily, DOFF (Remove) at NOC (Night) and for hygiene, check skin integrity every shift. R99's MDS, dated [DATE], showed R99 was cognitively intact, and R99 had an upper extremity impairment on one side. R99's POC (POC/Point of Care) Response History showed restorative splint/brace task. No documentation of splint being applied in the last 30 days. On 02/04/25 at 10:28 AM, R99 was in bed, awake and alert. R99's left hand was in a closed-fist position. R99 was unable to open her left hand. R99 stated she wears a splint and is waiting on a new splint. On 02/05/25 at 1:52 PM, R99 remained in bed. R99's left hand remained closed without a splint. R99 stated the staff still had not applied her splint. She stated she would like to wear a splint because she does not want her hand to continue to worsen. R99 stated she could not remember the last time she had a splint on. On 02/06/25 at 2:20 PM R99 continued to not have a splint on to her left hand. On 02/06/25 at 2:20 PM, V15 (Restorative Nurse) stated R99 has orders for a splint to be worn during the day. The splint is off during the night and for hygiene. V15 stated R99 wears a splint for the contracture of her left hand. V15 stated R99 should have had the splint on today and the last three days. V15 stated R99's contracture can worsen if she does not wear the splint. Facility's policy titled Restorative Nursing Program (8/18/24) shows: 1. Each resident will be screened and or evaluated by the nurse designated to oversee the restorative nursing process for inclusion in the appropriate facility restorative nursing program. The designated nurse will be responsible for the following: a. Obtaining orders for the resident's restorative program b. Documentation on a monthly basis (at a minimum) and c. initiation and updating restorative care plans .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46003 Based on observation, interview, and record review, the facility failed to securely store oxygen cylinders and cleaning supplies, and failed to maintain residents bed at a safe height to minimize potential injuries from falls. This applies to 17 of 17 residents (R2, R22, R34, R35, R39, R41, R44, R50, R57, R65, R105, R110, R126, R128, R129, R138, R141) reviewed for accident hazards in a sample of 30. Findings include: 1. R44's current care plan states she is at risk for fall. Interventions include to provide R44 with a safe environment. On 02/04/25 at 01:12 PM, R44's bed and overbed table were left in a very high position. R44 stated she needed to raise her bed to reach items on her overbed table. R44 stated no one ever told her it was not safe raise her bed to the high position. On 02/04/25 at 01:20 PM, V21 LPN (Licensed Practical Nurse) stated R44's table and bed shouldn't be left in that high position as it is not safe. R44 can adjust her bed up and down herself, but not her overbed table. On 02/05/25 at 01:06 PM, R44's bed and overbed table were left in a very position. R44 stated she did not raise her overbed table; it was raised when she woke up in the morning. R44 stated she raised her bed to eat her meals. On 02/06/25 at 10:09 AM, R44 told V15 she did not put her overbed table up; she elevated her bed to reach items on her overbed table. 2. R2's care plan states she is at risk for falls. Interventions include provide R2 with a safe environment keep bed in a low position On 02/06/25 at 10:14 AM, V15, LPN, was called to adjust R2's bed and overbed table that were left in a very high position. R2 told V15 the CNAs come in, put the bed in the high position, and don't put it back down. 3. On 02/04/25 at 12:34 PM, R22 bed and overbed table were left in a very high position. On 02/04/25 at 01:06 PM, V20, CNA (Certified Nursing Assistant), was called to R22's bedside to adjust the bed and overbed table to a safe position. V20 stated she thought R22 preferred her bed and overbed table left in a high position. V20 stated R22 is unable to adjust her overbed table as she requires assistance. On 02/06/25 at 09:56 AM, after providing care assistance to R22, V22, CNA, left R22's room with her bed in a very high position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/25 at 10:01 AM, V15, LPN (Licensed Practical Nurse), was called to R22's bedside. V15 stated when CNAs finish cares, they should make sure the bed is in the lowest position for safety in case the resident falls. On 02/06/25 at 10:07 AM, V22, CNA, stated R22 was not at risk for falls. Only residents at risk for falls need to have their beds lowered to a safe position. On 02/07/25 at 01:33 PM, V2, DON (Director of Nursing), stated, Staff should make sure the bed is left in the lowest position for resident who do not self-transfer or ambulate. It needs to be as low as possible so there is no impact from the fall. The facility policy Fall Prevention and management states all residents and patients will be considered at risk for falling regardless of fall risk score. Universal fall precaution interventions will be implemented to all. 4. On 02/05/25 at 02:51 PM, an unrestrained, unholstered, oxygen tank was in R126 and R138's bedroom. The tank contained 2,000 psi (Pounds per Square Inch) of oxygen. R34, R35, R39, R41, R57, R65, R105, R128, R129 are in rooms next to or across the hall from R126 and R138's room, and may be placed in danger should the oxygen tank inadvertently fall over and explode. On 02/05/25 at 02:55 PM, two oxygen tanks were unrestrained and unholstered in the second-floor mediation room. One tank was empty, and one tank contained 2,000psi of oxygen. V15, LPN, stated she did not know if the unrestrained oxygen tanks posed a risk by not being holstered. On 02/05/25 at 04:59 PM, R26, Maintenance Director, stated, For safety reasons, oxygens tanks should always be stored in a holder. Oxygen tanks are always delivered to the units in a holder. On 02/07/25 at 01:33 PM, V2, DON (Director of Nursing), stated, Oxygen cylinders need to be in a holder or properly stored and secured to keep them from falling over and combusting. Even empty cylinders pose a hazard of combustion because you never know how much residual oxygen is remaining in the tanks. Nursing staff are responsible to ensure the tanks are in a holder. The facility policy Oxygen, dated 04/2024, states all O2 tanks (medical gas cylinders) not in use must be in a tank holder and stored away in a secure room. The facility policy Oxygen Cylinder Safety Guidelines dated 06/06/2024 states oxygen cylinders must be protected from mechanical shock, falling objects etc. 5. On 02/05/25 at 02:58 PM, the second-floor soiled utility was not locked. R141 was observed wandering the second-floor touching things and people. On 02/05/25 at 03:03 PM, the housekeeping closet was not locked. V23, RN (Registered Nurse), stated it does not need to be locked. The housekeeping closet contained citrus neutral cleaner, all-purpose cleaner, glass cleaner, odor neutralizer in an unsecured dispenser, a ladder, large plastic grate and one gallon of neutral cleaner on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/05/25 03:04 PM, V24, Housekeeper, stated the housekeeping closet is never locked. On 02/05/25 at 03:14 PM, the housekeeping closet was not locked. The housekeeping closet contained citrus neutral cleaner, all-purpose cleaner, glass cleaner, odor neutralizer in an unsecured dispenser and one gallon of sanitizer disinfectant. On 02/07/25 at 01:33 PM, V2, DON (Director of Nursing), stated the soiled utility closet is never locked. The housekeeping storage closet should be always locked because chemicals are kept there. The facility did not provide a policy regarding locking housekeeping closets or soiled utility rooms or securing cleaning products.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview, and record review, the facility failed to assess incontinent residents for toileting programs and placed multiple layers of disposable incontinence products on a resident. This applies to 1 (R32) of 3 residents reviewed for incontinence care in the sample of 30. The findings include: On 02/04/25 at 11:07 AM, R32 was being assisted with toileting by V39 (CNA/Certified Nursing Assistant). R32 was wearing a disposable incontinence brief and a second disposable incontinence pad inside of the brief. On 02/05/25 at 1:44 PM, R32 stated she continued to wear an incontinence brief with an incontinence pad inside the brief. R32 stated she wears the briefs and pads for protection. R32 stated she was not on a toileting program/schedule. On 02/04/25 at 11:07 AM, V39 stated R32 drinks a lot of coffee and water. V17 stated she requires the pad and the brief due to her urine being heavy. On 02/06/25 at 2:25 PM, V15 (Restorative Nurse) stated residents should not wear an incontinence brief and an incontinence pad inside of the brief. V15 stated if R32 wears two incontinent briefs, she could be at risk for skin breakdown. V15 stated R32 is not on a toileting program. R32's Face Sheet showed R32 was admitted to the facility on [DATE], with multiple diagnoses which included hemiplegia and hemiparesis, diabetes, hypertensive chronic kidney disease, chronic obstructive pulmonary disease, major depressive disorder, and dysphagia. R32's MDS (MDS/Minimum Data Set), dated 01/02/25, showed R32 was dependent upon staff for toileting hygiene. R32's Restorative and ADL care plan showed no scheduled toileting program. The facility's Supporting Activities of Daily Living (ADL) policy (review date 11/07/24) showed Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 45906 Based on observation, interview, and record review, the facility failed to provide necessary services and care to maintain a midline intravenous (IV) catheter. This applies to 1 resident (R81) reviewed for IV catheter care in a sample of 30. The findings include: R81's Face sheet shows a diagnosis of unspecified hearing loss. On 2/4/25 at 2:25 PM, R81's right upper arm was observed with a midline intravenous catheter. The midline had a gauze underneath the transparent dressing that was saturated in serosanguinous (pink) blood. The midline dressing had no time, date, or staff member initial on it to show when the dressing was last changed or by whom, and the catheter had blood present in the tubing. R81 communicated in writing that he had the midline catheter for about a month, it was last used and flushed last month, and he could not recall the last time the dressing was changed. On 2/5/25 at 4:41 PM, V2 (DON/Director of Nursing) said the midline catheter dressing changes should be documented in either the MAR (Medication Administration Record) or the TAR (Treatment Administration Record). V2 then looked at both the MAR and TAR and no documentation of midline catheter dressing changes was present. V2 said when a nurse changes the midline catheter dressing, he/she should date the dressing so the next staff member taking care of that resident knows when the dressing was last changed. V2 said other than in a progress note, there is no other place where a nurse would document midline catheter dressing changes. V2 then looked at all of the progress notes from 1/22/25 through 2/5/25, and found no documentation of midline catheter dressing changes. V2 said the midline catheter dressing changes should be done weekly and as needed. V2 was asked if the dressing changes were still once a week if there was a gauze under the transparent dressing and she said yes. V2 was then showed the facility's policy on midline intravenous catheter care and she said she did not know that a midline catheter dressing needed to be changed every 48 hours if there was a gauze under the transparent dressing. R81's POS (Physician Order Sheet) shows an order dated 1/20/25 for IV (Intravenous) midline to be placed for antibiotic infusion every 6 hours for 10 days. R81's MAR shows he has not received any IV medications in February. R81's POS does not show any other orders regarding midline catheter dressing changes, flushes or care. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Peripheral and Midline Intravenous Catheter Care and Dressing Changes (revised November 2022) states, Policy: The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter related infections associated with contaminated, loosened or soiled catheter-site dressings. General Guidelines .1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened, or visibly soiled) .4. Change the dressing if it becomes damp, loosened or visibly soiled and: .b. at least every 2 days for sterile gauze dressing (including gauze under a TSM (transparent semi-permeable dressing) unless the site is not obscured); or c. immediately if the dressing or site appears compromised .6. Assess the peripheral/midline access device at least every 4 hours .a. visually inspect the entire infusion system (solution, administration set, and dressing); b. Check expiration dates of the infusion, dressing and the administration set; .d. Palpate and inspect the skin, dressing and securement device for signs of complications, including: .(8) drainage; .Equipment and Supplies .Steps in the Procedure .9. Place new dressing (TSM or gauze) over insertion site. Label dressing with the date and time of dressing change, and initials. Documentation: 1. The following should be documented in the resident's medical record: a. Date, time, type of dressing, and reason for dressing change .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46003 Based on interview and record review, the facility failed to provide completed documentation of the pharmacy's monthly MRR (Medication Regimen Reviews) recommendations with the physician / prescriber response. This applies to 2 of 5 residents (R55 and R64) reviewed for unnecessary medications in a sample of 30. Findings include: 1. The EMR (Electronic Medical Record) for R55 documents the consultant pharmacist completed MRR and referenced see report for any irregularities and or recommendations on 05/17/2024, 06/14/2024, and 09/06/2024. The facility did not provide the referenced reports or documentation of the physician's responses to the recommendations. On 02/06/25 at 01:03 PM, V3, ADON (Assistant Director of Nursing), stated, We need a better tracking system. V3 stated the pharmacist emails her the recommendations and she puts the recommendations in the physician's mailbox. She lets them know the recommendations are in their mailboxes. V3 stated she should be following up with the physicians for their recommendations. V3 stated some of the pharmacist recommendations are missing and she doesn't know what happened to them. The recommendations do not always get scanned in the EMR. The recommendations with responses should be a part of the resident's medial record. V3 ADON stated there is no time frame in which the physician should review the recommendations, it should just be as soon as possible. On 02/07/25 at 01:33 PM, V2, DON (Director of Nursing), stated, Monthly MRR are sent to the ADON. (V3) should either place the pharmacy recommendations in the physician's mailbox, hand deliver them to the NP (Nurse Practitioner) or call the physician or NP. If she does not get a response for the recommendations, she should escalate up the chain to the Medical Director. (V3) has notified me at times when she has not heard back from physicians. There should not be any missing unless Physician or NP did not return them. (V3) should still have the email with the pharmacy recommendations. V2, DON, stated V3, ADON, should notify her if she is not getting a response to the pharmacy recommendations. V2 stated the recommendations should be addressed before the following month. 2. The EMR for R64 documents the consultant pharmacist completed MRR and referenced see report for any irregularities and or recommendations on 01/19/2024, 02/16/2024, 04/25/2024, 07/12/2024. The facility did not provide the referenced reports or documentation of the physician's responses to the recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Documentation and Communication of Consultant Pharmacist Recommendations, dated November 2021, states comments and recommendations concerning mediation therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. In the even of a problem requiring the immediate attention of the prescriber, the responsible prescriber or physician's designee is contacted by the consultant pharmacist or the facility, and the prescriber's response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record. Recommendations are acted upon and documented by facility staff and or the prescriber. If the prescriber does not respond to recommendations directed to him / her in a reasonable time period, the Director of Nursing and or the consultant pharmacist may contact the Medical Director.

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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. 46003 Based on observation, interview, and record review, the facility failed to maintain the kitchen facility in a manner to prevent foodborne illness. This applies to 133 residents in the facility receiving dietary services. Findings include: On 02/06/25 at 12:08 PM, V17, Dietary Manager, confirmed 133 residents were being served from dietary services. 1. On 02/04/25 at 10:15 AM, the vents located over the stove cooking surface were dusty. One of two red sanitizing buckets sanitizer tested at 500 ppm (Parts Per Million). The three-compartment sink sanitizing solution tested at 500 ppm. The dishwasher was being utilized to clean dishware. The temperature sensitive strips were run through the dishwasher and did not turn black to indicate the appropriate sanitizing temperature had been achieved. During the test run the digital reading highest temperature was 99-degree Fahrenheit. V17 stated the dishwasher disinfects by temperature and should have a final rinse of 180 degrees Fahrenheit. V19, Morning Cook, stated he last filled the sanitizing sink, and it tested at 300ppm. V19 stated the sanitizing solution is automated and dispense when he turns the dial. V19 wrote down 300ppm on the log, stating he forgot to write it down earlier. On 02/06/25 at 12:08 PM, V17 stated the red sanitization buckets and 3 compartment sink sanitization level should be between 200-400 ppm per the manufacturer. 300ppm is not a choice on the testing strips but if the color falls between 200 and 400 staff can guestimate. If the dishwasher doesn't reach 180 degrees Fahrenheit, they can't verify the dishes are sanitized. The sink could have been used, but the automated sanitizer dispenser wasn't working well either and the dishes would need to air dry before use. The undated facility provided policy 3 compartment sink states, check sanitization sink frequently using test strips to assure the level of sanitizing solution is appropriate. Follow chemical manufacturers' s guideline to prepare sanitizing solution. The undated facility provided policy Sanitizer Buckets states compare color test strip to manufacture's color chart to decipher if solution is the correct concentration. Record ppm on sanitization log. The sanitizer product information sheet states when used as directed the product is for use as a sanitizer on dishes glassware and utensils at 200-400ppm active quaternary without potable water rinse. It is a violation of federal law to use product in a manner inconsistent with its labeling. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 02/04/25 at 09:37 AM, the walk-in cooler contained items that were not labeled to identify contents and had a single date. A block of yellow sliced cheese accessed and wrapped in plastic dated 2/3 Four small cups with pickles dated 1/30. Eleven cups identified by V18 as cottage cheese dated 2/1 and one cup dated 1/30. Peanut butter and Jelly sandwich dated 2/1 A sandwich bag identified by V18 as ham and cheese labeled with an S and dated 2/2 Eight cups identified by V18 as lactose free milk dated 2/2. Two rotten tomatoes one with black spots one with white spots. Eleven wrinkled and wilted green peppers. An accessed 5 lb. (pound) bag of cheddar cheese labeled use first dated 1/30 An accessed 5 lb. bag of cheddar cheese opened on 1/29 use by date 2/1/25 Manufacturer wrapped turkey breast stored over a metal facility pan identified as diced beets and dated 2/2/25. Meat wrapped in plastic identified by V17 as sliced turkey labeled use first dated 2/2 Two packages of meat wrapped in plastic identified by V17 as sliced ham dated 2/2 Meat wrapped in plastic identified by v 17 as sliced turkey dated 2/2. Twenty-eight bowls of salad dated 2/1 Eighteen containers identified a cottage cheese dated 2/1 and one dated 1/3. Seventeen sandwiches identified as ham and cheese dated 2/2 Metal tray containing sliced mushy tomatoes, lettuce, sliced onion and cheese slices date 2/4 A tray labeled employees food with a 2-liter bottle of ginger ale and an apple. On 02/06/25 at 12:08 PM, V17 stated food should be labeled when it was delivered, or the with the manufacture's use by date if it taken out of the original container and a use by date added. V17, Dietary Manager, stated it is ok for staff to keep their personal food in the kitchens refrigerator if it is labeled for staff, adding there is no eating or drinking in food prep area because there is a risk for contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The undated facility policy Labeling and Dating states leftovers and open foods shall be clearly labeled with date food item is to be discarded. Seven-day shelf life including date of preparation - label includes name of food item, discard date, some health departments also require preparation date. Thirty-day shelf-life label includes name of food item, discard date (i.e. opened date, discard date) The facility policy Food Storage (Dry, Refrigerated and Frozen), dated 8/12/2023, Refrigerated Foods states, open products are sealed, labeled and dated. Raw food is stored below cooked or ready to eat foods. The facility provided Proper Cold Food Storage shows ready to eat food stored above poultry. The facility policy Staff Personal Food Storage, dated 6/14/19, states food brought in by staff will be identified with name of owner and date placed in designated refrigerator. On 02/04/25 at 10:10 AM, the walk-in freezer contained a clear bag identified by V18 as pork patties, dated 1/26, and a clear bag identified as chicken nuggets open to air without a label or dates. The facility policy Food Storage (Dry, Refrigerated and Frozen), dated 8/12/2023, Frozen Foods states, if taken out the original packaging, product is labeled and dated. 3. On 02/05/25 at 02:39 PM, the first-floor resident refrigerator was reviewed with V4, LPN (License Practical Nurse). There was no thermometer in the refrigerator. The temperature log on front of the refrigerator was blank and the freezer section was built up with ice. There was a 240 ml (Milliliter) carton of chocolate milk with a sell by date of 1/27/25. There were two take-out containers containing spaghetti and meatballs with no labels or dates. On 02/05/25 at 02:43 PM, the second-floor resident refrigerator was reviewed with V23, RN (Registered Nurse). The refrigerator contained two take-out containers that were not labeled and dated. There were no thermometers in the refrigerator, and it felt warm and there was no temperature log. On 02/05/25 at 04:33 PM, V1, Administrator, stated there were no temperature logs for the resident refrigerators. The temperature checks are not being done. There should be a thermometer in all the refrigerators. The receptionists are responsible for checking both unit food refrigerators. V1 stated the refrigerator temperatures could not be checked without thermometers in place. On 02/05/25 at 05:12 PM, the first-floor resident refrigerator was observed with V26, Maintenance Director. There was no thermometer, and the temperature log was blank. At 05:21 PM, the second-floor resident refrigerator was observed with V26. There was now a thermometer the freezer section was 15-degrees Fahrenheit. The refrigerator was 50 degrees Fahrenheit. The facility did not provide a policy for resident unit refrigerators. The facility policy Food Storage (Dry, Refrigerated and Frozen), dated 8/12/2023, Refrigerated Foods states, foods are stored at 41 degrees Fahrenheit or below. 4. On 02/04/25 at 09:25 AM, the kitchen tour began with V17, Dietary Manager, and V18, Regional Director. The dry storage area contained dented cans stored on slanted shelves and were not marked as dented. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Strawberry filling 7 lbs. (Pounds) Pumpkin puree 6lb 10oz (ounces) Sliced olives 3lbs 7 oz Sliced peaches 3lbs 10 oz Diced potatoes 6lbs 4 oz On 02/06/25 at 12:08 PM, V17 stated if a dented can is inadvertently used, there is a chance for botulism to develop and cause food borne illnesses. The undated facility provided policy Storage of Dry Foods states dented cans shall be stored separately or immediately returned to the food vendor. If dented cans are stored in the storeroom, they shall be clearly marked to prevent usage.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview, and record review, the facility failed to ensure that resident's personal food items were properly stored. This applies to 1 (R45) of 3 residents reviewed for stored food in the sample of 30. The findings include: R45's Face Sheet showed she was admitted to the facility on [DATE], with multiple diagnoses which included chronic obstructive pulmonary disease, morbid obesity, major depressive disorder, acquired absence of right and left fingers, and heart failure. R45's MDS (MDS/Minimum Data Set), dated [DATE], showed R45 was cognitively intact. On [DATE] at 11:09 AM, R45 had an opened bottles of Miracle Whip (19 ounces) and horseradish sauce (12 ounces) stored in the windowsill in her room. Both bottles stated to refrigerate after opening. R45 stated she used to have a refrigerator in her room, but the company removed the refrigerator. R45 stated she has nowhere else to store her personal food items since there is no refrigerators. R45 stated she uses the condiments often. On [DATE] at 3:31 PM, the undated Miracle Whip and horseradish sauce remained in the windowsill. On [DATE] at 3:14 PM V1 (Administrator) stated, Currently we do not have any personal refrigerators in the facility. We used to have them, and the staff did not check or clean the refrigerators. The food must be labeled and dated. Residents should not store miracle whip and horseradish sauce in a windowsill and those items should be stored in a refrigerator. If residents eat foods that should be stored in the refrigerator, they could become sick and have digestion issues. The facility's Food Storage policy review date ([DATE]) showed Enforcement & Compliance: regular weekly inspections will be conducted by staff. Spoiled, expired, or improperly stored food will be discarded immediately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 31327 Based on observation, interview, and record review, the facility failed to wear the appropriate PPE (Personal Protective Equipment) before entering a isolation room. This applies to 1 of 4 resident (R447) reviewed for infection control in a sample of 30. The Findings include: R447's face sheet shows diagnoses of infection of amputation stump, right lower extremity, non-pressure chronic ulcer of other part of left lower leg with unspecified severity, MRSA infection, unspecified site, MRSA as the cause of diseases classified elsewhere, and acquired absence of right leg below knee. R447's POS (Physician Order Sheet) shows an order for Transmission based precautions: Contact Precautions for IV (Intravenous) Antibiotics for Wound Infection with MRSA+ culture. R447's care plans show she has MRSA. Interventions: Maintain isolation precautions as indicated and as ordered. Instruct family/visitors/caregivers to wear disposable gown and gloves during physical contact with resident. Discard in appropriate receptacle and wash hands before leaving room. On 2/4/25 at 2:00 PM, V11 (CNA-Certified Nursing Assistant) was observed delivering water to the residents. At 2:05 PM, V11 put on gloves and went to R447's room without wearing a gown. Outside of R447's door, there was a sign on her door that said Contact Precautions. V11 stated, I saw (R447)'s call light went off. I went to her room. She wanted her wipes. I put them on her table, and she used the wipes to wipe herself. It dawned on me that I didn't wear a gown. (R447) is on contact precautions because she has MRSA (Methicillin-Resistant Staphylococcus Aureus). I should have worn a gown. I'm sorry. On 2/5/25 at 12:43 PM, V2 (DON-Director of Nursing) stated, MRSA is contact precautions. Staff has to wear the proper PPE (Personal Protective Equipment), which is gown and gloves before they go to a contact isolation room. Facility's policy titled Isolation-Categories of Transmission-Based Precautions (5/31/24) shows the following: Contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. 5. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after the gown is removed.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 46409 Based on interview and record review, the facility failed to utilize an antibiotic use protocol tool for residents who were placed on antibiotics. This applies to 2 of 5 residents (R27, R120) reviewed for antibiotic stewardship in a sample of 30. The findings include: On 2/6/25 at 11:24 AM, V4 (IP/Infection Preventionist) was interviewed regarding antibiotic stewardship. At 3:05 PM, V4 said they should use the tool when they suspect a resident has an infection, which should be done right away. V4 said it helps the staff to screen for infections. 1. R27's EMR (Electronic Medical Record) was reviewed with V4, and showed he was receiving Ciprofloxacin 500 MG (Milligrams) every 12 hours started on 2/5/25 and ending 2/15/25. V4 said the Infectious Disease Nurse Practitioner ordered the antibiotics on 2/4/25 at 2:48 PM. V4 said the McGeer's tool was not completed, and it should have been done. R27's face sheet showed R27 was admitted to the facility with diagnoses including urinary tract infection and encounter for fitting and adjustment of urinary device. 2. R120's EMR was reviewed with V4, and showed he was receiving Meropenem Intravenous 500 MG every 12 hours for a positive sputum culture starting on 2/1/25 and ending on 2/14/25. V4 said the McGeer's tool was not completed for this antibiotic. V4 said he as well as the floor nurses would be able to fill out the McGeer's tool. R120's face sheet showed he was admitted to the facility with diagnoses including osteomyelitis of vertebra, candidiasis, abnormal sputum, elevated white blood cell count, and encounter for attention to tracheostomy. On 2/6/25 at 3:43 PM, V2 (DON/Director of Nursing) said the McGeer's tool is used for antibiotic stewardship. V2 said the tool should be completed if there was a suspected infection and was used to determine whether it was a true infection. V2 said the tool would show whether the resident met the criteria for having an infection. The facility's Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes reviewed June 2, 2024 showed Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 46003 Based on observation, interview, and record review, the facility failed to identify an area of possible entrapment on a resident's bed. This applies to 1 of 17 residents (R22) reviewed for safety. The findings include: On 02/04/25 at 12:34 PM, R22's bed and overbed table were left in a very high position. R22's side rails extended approximately five inches on both sides of her bed. On 02/06/25 at 10:01 AM, V15, LPN (Licensed Practical Nurse), was called to R22's bedside. R22's bed rails are too far apart from the mattress and bed frame. She could roll over and become stuck between the rails. On 02/07/25 at 01:33 PM, V2, DON (Director of Nursing), stated, Maintenance and Nursing should make sure there is not space between the bed rail and mattress. We don't want to risk anyone being injured from lying on a metal frame or becoming entrapped. The facility policy Resident Bed, dated 1/17/2025, states the facility will conduct regular inspection of all bed frames, mattress and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment.