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	05/07/2026

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 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 observation, interview, and record review, the facility failed to assure the facility dishwasher consistently achieved the required temperature to disinfect facility dishware.This applies to all 125 residents that receive dietary service from the facility kitchen.Findings include:On 05/05/2026 at 3:24 PM, V1 Administrator stated 125 residents were receiving meals services at start of the survey.On 05/05/2026 at 10:25 AM, the kitchen tour began with V13 Regional Operations-Dietary and V22 Dietary Manager. V13 stared the dishwasher disinfected by temperature and the final rinse should be a minimum of 180 degrees Fahrenheit. Four dish load cycles were observed. The first final rinse temperature was 174 degrees Fahrenheit. The second final rinse temperature was 185 degrees Fahrenheit. The third final rinse temperature was 164 degrees Fahrenheit. The fourth final rinse temperature was 175 degrees Fahrenheit.V13 stated the dishes would need to be sanitized manually until the dishwasher is serviced.V14 Dishwasher stated she tested the final rinse that morning, but she didn't remember what it was. V14 stated she looks at the digital reading while she is doing the dishes and it was fine. V14 stated that when the dish machine is not working properly, she should inform her supervisor.On 05/07/2026 at 12:43 PM, V20 Maintenance Director stated he was notified by the kitchen staff that last month there was a problem with the dishwasher. The repair company came out to repair a steamer and a pilot on an oven and he mentioned the dishwasher to them at that time, but they are unable to complete the dishwasher repair until a part that was ordered is received. V20 stated he called the repair company to come out to make repairs and had no documentation of the call or their visits to the facility.On 05/07/2026 at 1:02 PM, V19 Dishwasher stated he had previously informed V20 of problems with the dishwasher but did not recall the specific date. V19 stated he was not informed that while the dishwasher is waiting to be repaired, he should be using the three-compartment sink to sanitize the dishes and utensils. The three-compartment sink has only been used for the pot and pans.The dish machine temperature logs were reviewed for February, March, April and May 2026. The digital readings were recorded every day for each meal. Everyday for breakfast lunch and dinner the recorded wash temperature was 160 degrees Fahrenheit. Everyday for breakfast, lunch and dinner the rinse temperature was 160 degrees Fahrenheit. Everyday for breakfast, lunch and dinner the final rinse temperature documented was 180 degrees Fahrenheit.The undated facility policy Dish Machine Temp states the dishes pots, pans, utensils, cups, mugs, bowls etc. will be washed using procedure, chemicals and equipment that result in clean, sanitized items. High temperature machine temperatures, as required by the manufactured are wash from 150-165 Final Rinse 180 to 195. If temperature reads incorrectly notify the department head and / or inform maintenance department (usually by work order form). If unable to repair the dish machine by the next meal the meal ay be served on disposable plates with plastic utensils OR the dishes and flatware maybe washed in the three-compartment sink following standard procedures.The undated facility policy Equipment Failure and Repair states dining services equipment shall be maintained in a good state of repair. Staff is trained to report equipment that does not work or is not functioning properly. Supervisor or staff member reports problem to maintenance department according to facility procedure giving as much detail as needed to describe the problem. Outside (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	repair service is called if the problem cannot be corrected in a reasonable time frame by the facility maintenance staff.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to prevent and treat for an insect infestation in the kitchen area.This applies to all 125 residents that receive dietary service from the facility kitchen.Findings include:On 05/05/2026 at 3:24 PM, V1, Administrator, stated 125 residents were receiving meals services at start of the survey.On 05/05/2026 at 10:25 AM, the kitchen tour began with V13 (Regional Operations-Dietary) and V22 (Dietary Manager). Black flying insects were present at the kitchen sink. In the dry storage area of the kitchen, there was a swarm of flying black insects. V13 denied being informed of problems with flying insects in the kitchen area. V13 stated she was unaware if the pest control company had previously noted or treated for any flying insects.On 05/07/2026 at 12:36 PM, V21 (Dietary Aide) stated he has seen the flying bugs in the kitchen, but he did not mention it to anyone.On 05/07/2026 at 12:43 PM, V20 (Maintenance Director) stated pest control came out the day before for bugs seen in the kitchen, but they did not provide him with a report. V20 stated he had no documentation of the pest control visit.The service inspection report from the pest control company, dated 04/29/2026, lists a Norway rat found in the laundry room. No other pest activity is documented on the report. No product application was utilized in the facility to treat any pest activity.The facility policy Pest Control, dated 5/15/2025, states the intent is to provide a healthy environment for residents.The facility's pest control policy does not provide direction on what to do when pest activity is discovered.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prioritize resident discharge goals and preferences and facilitate timely discharge.This applies to one resident (R8) reviewed for discharges in a sample of 30 residents.Findings include:On 5/5/26 at 12:58 PM, R8 said she has been trying to get discharged to another facility. R8 said every time she calls the outside facility, their Social Worker tells R8 she is waiting on documentation to approve the transfer. R8 said the outside facility told R8 they need documentation saying R8 is not contagious, and this is the only thing holding up R8's transfer. R8 said she has been working with V6 (Social Service Director) to get the requested documentation sent.R8's Discharge summary, dated [DATE] by V6 (Social Service Director), states R8 will be discharged to facility in (city, state) on 4/2/26 per the resident's request. V6 did not document any follow up note after 4/1/26 stating why R8 was not transferred.On 5/6/26 at 2:09 PM, V6 (Social Service Director) said R8 is not under isolation and is not contagious. V6 said the facility in (city) said they needed documentation to prove some type of test, that she could not recall the name of, was negative. V6 said she was told by V3 (ADON/Assistant Director of Nursing) the facility does not have any paperwork showing R8 is negative for this specific bacterium or that the bacteria was inactive/dormant. On 5/6/26 at 2:55 PM, V6 said she does not have any other documentation regarding R8's transfer/discharge planning since V6's Discharge Summary note from 4/1/26. V6 said she talked to V3 (ADON) and V3 told V6 the bacteria that R8 had tested positive for in the past was Candida Auris also known as C. Auris. V6 said V3 told her R8 will always show up positive for C. Auris and there is no testing the facility could do to provide the requested not contagious documentation to the facility in (city). On 5/6/26 at 3:21 PM, V6 said she last spoke to R8 on 4/20/26 and told R8 she was still trying to get the requested documentation. On 5/6/26 at 3:24 PM, V3 said she is not sure where R8 had Candida Auris in the past, but usually once you have it, you will always test positive for it. V3 said she did not know when R8 was last tested for Candida Auris.R8's EMR (Electronic Medical Health Record) shows documentation from 4/13/26 by V28 (Infectious Disease Nurse Practitioner) stating patient requested to be transferred to an outside facility but was rejected due to history of C. Auris. Patient tested positive for C. Auris in the urine in October 2024. She exhibits no acute symptoms of infection and is asymptomatic currently. R8's urinalysis, culture and sensitivity from 11/14/24 and 9/9/25 were negative for candidal growth. Patient is safe for discharge form Infectious Disease standpoint with no concern for acute candidal (C. Auris) infection.On 5/6/26 at 3:47 PM, V6 (Social Service Director) was asked if she had reviewed the Infectious Disease note from 4/13/26, and she said she did not think to look at the notes. V6 said she was going by what V3 was telling her. V6 said if she had seen the note, she would have sent it to outside facility to get R8 transferred. V6 said she should have documented follow up social work notes in R8's chart regarding the discharge planning, and she does not know what happened, sometimes she gets distracted. On 5/7/26 at 2:01 PM, V1 (Administrator) said it is important to document the discharge planning process in the resident's chart so that all staff know where the resident is at in the process to facilitate a successful timely discharge. V1 said it is a concern R8 had discharge clearance from Infectious Disease last month that was missed. V1 said R8's transfer to her desired facility could have and should have been arranged sooner.The facility's policy titled, Discharge Planning, last revised 12/2025, states, Policy Statement: It is the policy of the facility to provide an ongoing, resident-centered discharge planning process that focuses on the resident's goals, preferences, needs, strengths, and post-discharge care requirements to support a safe and appropriate transition form the facility to another level of care, community setting, or home environment. The facility will ensure that discharge planning begins upon admission, is reviewed throughout the resident's stay, and involves the resident, representative, interdisciplinary team, and other appropriate individuals as (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	necessary.Purpose: The purpose of this policy is to: promote safe, timely, and appropriate discharge transitions.support residents rights, preferences, and informed choices.Policy Guidelines.2. Interdisciplinary Team (IDT) Participation: The discharge planning process will involve the interdisciplinary team. The team will collaborate to ensure continuity and coordination of care.8 Documentation Requirements: The medical record will include documentation of: discharge planning discussions, resident goals and preferences, participation of resident/representative, IDT involvement, referrals and arrangements made, education provided.communication with receiving providers/agencies.Procedure:.During Stay:.3. Necessary referrals and arrangements will be initiated timely.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide personal hygiene for residents who required assistance from staff.This applies to 3 of 3 residents (R93, R48, R34) reviewed for ADLs (Activities of Daily Living) in a sample of 30. The findings include: 1. On 05/05/26 at 10:08 AM, R93's nails were 1.5 cm (Centimeters) long and had brown substances underneath them. R93 said she could not see the dirt underneath her fingernails. On 05/07/26 at 12:37 PM, R93's nails were still 1.5 cm long and had brown substances underneath them. R93 said she did not like having dirt underneath her nails and asked who was going to clean them for her. R93's face sheet showed she was admitted to the facility with diagnoses including lack of coordination, cognitive communication deficit, emphysema, type 2 diabetes mellitus, dementia, and adjustment disorder. R93's MDS (Minimum Data Set), dated 03/21/26, showed R93 had mild cognitive impairment and required moderate assistance with personal hygiene. R93's Care Plan, dated 09/25/24, showed R93 has an ADL self-care performance deficit related to activity intolerance, fatigue, limited mobility, weakness, decrease strength, low activity tolerance. 2. On 05/05/26 at 10:15 AM, R48 had facial hair that was two inches long on her chin. On 05/07/26 at 12:50 PM, R48 still had facial hair that was two inches long on her chin. R48 said she did not like having facial hair and wanted it to be removed. R48's face sheet showed she was admitted to the facility with diagnoses including polyosteoarthritis, peripheral vascular disease, paranoid schizophrenia, and bipolar disorder. R48's MDS, dated [DATE], showed R48 had moderate cognitive impairment and required supervision for personal hygiene. R48's Care Plan, dated 05/05/20, showed Restorative Program: R48 is placed on dressing and grooming due to weakness at times and a Care Plan, dated 07/28/22, which showed R48 has an ADL self-care performance deficit [related to] decreased mobility and cognitive loss. On 05/07/26 at 12:40 PM, V10 (CNA/Certified Nurse Assistant) said facial hair and nail care were provided to residents on their shower days. V10 said the staff should clean underneath the residents' nails because they could scratch and get dead skin and dirt under their nails and could cause an infection, especially if the brown substances were feces. V10 said R93's nails should not have brown substances, and they should be clean. V10 said they would notify the nurse if the resident refused nail or facial hair care. At 12:52 PM, V10 said R48 would not refuse if asked if she wanted her facial hair removed. On 05/07/26 at 12:45 PM, V11 (CNA) said on shower days, she provided nail and facial hair care for the residents. V11 said if the residents wanted to keep their nails long, they would need to clean underneath the nails to make sure there were no substances underneath them, which could cause an infection. V11 said R93's nails should not have dirt underneath them. 3. On 05/05/26 at 12:44 PM, R34 was in bed. R34 had an accumulation of facial hair. R34's hair was long, greasy, and uncombed. R34 stated he had asked for a shave several times from the staff. R34 stated he had not gotten a shave in a long time. On 05/07/26 at 10:45 AM, R34's continued to have full and thick facial hair. R34's hair remained long, greasy and uncombed. R34 stated he told the staff he wanted to be shaven, and get his hair washed and trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/26 at 10:55 AM, V24 (Registered Nurse) stated R34's hair should not be greasy, long, and uncombed. V24 stated R34 should not have an accumulation of facial hair. V24 stated the staff should be assisting R34 with ADL care on shower days and as needed. On 05/07/26 at 9:58 AM, V2 (Director of Nursing) stated residents should not have full, long facial hair. V2 stated their hair should not be long, greasy, and uncombed. V2 stated it is expected that the staff will give showers and perform hygiene as ordered and as needed. R34 was admitted to the facility on [DATE], with multiple diagnoses which included chronic obstructive pulmonary disease, diabetes, end stage renal disease, major depressive disorder, and osteoarthritis. R34's ADL self-care performance deficit care plan, dated 11/15/23, showed, Deficit related to weakness, decrease strength, limited mobility, and low activity tolerance. R34's MDS, dated [DATE], showed R34 required partial to moderate assist with shower/bathing, and supervision or touching assistance with personal hygiene. The facility's Activities of Daily Living Support with Showers, date reviewed 01/18/26, showed, 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. 2) Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care).

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide foot care to a diabetic resident.This applies to 1 of 1 residents (R88) reviewed for podiatry services in a sample of 30.Findings include:R88's diagnoses include congestive heart failure, type two diabetes, muscle wasting and atrophy, morbid obesity, end stage renal disease, and bilateral osteoarthritis of knees. R88's face Sheet showed she was admitted [DATE].On 05/05/2026 at 12:16 PM, R88 was sitting on the side of her bed with bare feet exposed. R88's feet were dry and crusty. Her toenails were long and jagged. R88 toes had a black-tipped French polish that had grown out well past the nail bed. R88 stated she hadn't had her nails cut in about five months. R88 stated she had requested from multiple staff to see the podiatrist for some time and had not been seen. R88 stated her son would take her to the nail shop but she wouldn't be able to get in their chairs to put her feet in the bowls to have a pedicure.On 05/06/2026 at 4:02 PM, V16, C.N.A. (Certified Nursing Assistant), assigned to R88, stated he couldn't think of any of his residents that needed to be seen by the podiatrist. V16 stated he does not cut toenails; he marks on the shower sheets residents that need to have their nails cut. The shower sheet is signed by the nurse then submitted to the DON (Director of Nursing). V16 stated there is also a podiatrist list at the nursing station that residents' names could be added to.On 05/07/2026 at 10:44 AM, V18, LPN (Licensed Practical Nurse), stated in her experience the Social Worker usually sets up podiatry appointments. V18 stated no one informed her R88's toenails needed to be cut. R88's toenails looked like they had been growing longer than six months. V18 stated R88 is a diabetic and she could be seriously injured if one of her toenails was bumped and broke off and put her at risk of infection. R88 stated her toenails looked like she could use them to climb a wall.On 05/07/2026 at 11:04 AM, V15, C.N.A, assigned to R88 stated she has taken care of R88 before but had never looked at her toes. V15 stated she washes R88, changes her brief, but had not previously noticed her toes. V15 stated normally she would have reported the toenails to the nurse but had not reported that R88 needed her nails cut.On 05/06/2026 at 3:26 PM, V6 Social Services Director stated the nursing staff add residents' names to a list to be seen by the podiatrist that is kept at the nursing station. V6 stated sometimes she gives the list to the podiatrist and sometimes he takes the list from the station himself. V6 stated she had the current lists available but did not have the podiatry list from previous months. V6 stated the podiatrist comes to the facility once per month and the list is not a guarantee that all residents will be seen by the podiatrist for that month. V6 stated after the podiatrist sees the residents, he emails her his after-visit assessment. V6 stated R88 had not been seen by a podiatrist since her admission to the facility.On 05/07/2026 at 1:23 PM, V2, DON (Director of Nursing), stated toenails are a part of foot care. Diabetics toenails should be kept cut to prevent the development of an infection or ingrown nails.The podiatrist list for May 2026 did not have R88 listed. R88 did not have any shower sheet completed prior to survey indicating she required her toenails be cut.The facility policy Foot Care, dated 05/20/25, states it is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental and psychosocial needs.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to assess a resident for limited ROM (range of motion) and implement interventions to prevent a decline in ROM. This applies to 2 of 6 residents (R90 and R113) reviewed for Range of Motion in a sample of 30.Findings include: 1.On 05/05/2026 at 12:30 PM, R90's right hand was formed into a tight fist. R90 stated he was unable to stretch or open his right hand due to a stroke. R90 stated he did not have any type of splint or anything being done to keep his hand from staying in the first position. On 05/06/2026 4:02 PM, V16, C.N.A. (Certified Nursing Assistant), assigned to R90, stated R90 did not have a splint for his right hand. On 05/07/2026 at 10:09 AM, V17 (Restorative Nurse) went to R90's bedside to do an assessment. V17 stated she had just started at the facility at the beginning of the week and had not seen R90 before. V17 stated R90 was being seen by Restorative Services for bed mobility and dressing. V17 stated R90's previous documentation showed he had moderate limitation of strength to his right side; no mention of limited ROM (Range of Motion) to right wrist and fingers. V17 stated assessing R90 at bedside, she was unable to extend his right hand and fingers past thirty degrees. Interventions that could have been put in place to prevent R90's decrease in range of motion could have been PROM (Passive Range of Motion) as tolerated or a palm splint. R90's mobility assessment, dated 03/24/2026, states he has full ROM to his right elbow, wrist, and fingers. R90's updated assessment, dated 05/07/2026, states R90's right elbow ROM flexion decreased to moderate and his right wrist and fingers flexion and extension were now poor. R90's current care plan states R90 had a Cerebral Vascular Accident (CVA / Stroke). The resident will be free from signs / symptoms of complications of CVA. Interventions include monitor / document mobility status. If the resident is presenting with problems or paralysis, obtain order for physical therapy and occupational therapy to evaluate and treat. 2. R113 was admitted to the facility on [DATE] with multiple diagnoses which included aphasia, Wernicke's' Encephalopathy, major depressive disorder, and neuromuscular dysfunction. R113's Minimum Data Set/MDS, dated [DATE], showed R113 was cognitively intact. The same MDS showed R113 had impaired functional limitation to both of her upper and lower extremities. R113's Order Summary Report for May 2026 showed, (R113) has a contracture to the right hand/wrist. R113 has slight contraction to middle finger on left hand. Apply palm protector/rolled towel to right and left hand daily. Check skin integrity periodically. May remove splint for ADL/hygiene tasks and NOC (night). Ordered 03/05/2025. R113's contracture care, plan dated 11/27/23, showed, (R113) has a contracture to right hand/wrist. (R113) will decrease further contracture risk by next review. Apply palm protector/rolled towel to right hand daily. May remove splint for ADL/hygiene tasks and NOC. R113's contraction to middle finger on left hand care plan showed, Preserve functionally in daily activities. Apply palm protector/rolled towel to left hand daily. May remove splint for ADL/hygiene tasks and NOC. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/05/26 at 11:33 AM, R113 was sitting in a high back wheelchair. R113 was unable to open both hands. R113's first fingers were extended on both hands; all other fingers were in a closed position. R113 was not wearing a splint, palm protectors, or rolled up towels in her hands. R113 stated she does not wear a splint/palm protectors and does not receive any exercises to her hands. On 05/06/26 at 2:54 PM, R113 was in bed sleeping. R113 continued to not be wearing splints, palm protectors, or rolled up towels in her hands. Both of R113's hands remained in the closed position with the first fingers on each hand extended. On 05/06/26 at 3:16 PM, V26 (Director of Rehab) stated R113 was not receiving any services through therapy at the moment. V26 stated R113 had never been evaluated for OT (Occupational Therapy). V26 stated he was not aware of the NP (Nurse Practitioner) writing an order on 04/16/26 for OT. On 05/06/26 at 3:29 PM, V2 (Director of Nursing) stated when an order is put in for OT, the resident should be evaluated. V2 stated she had no knowledge of an order written by the NP for R113 to receive OT. V2 stated if an order is given to the nurse for therapy, it is the nurse's responsibility to notify therapy. V2 stated R113 is supposed to wear palm protectors. On 05/06/2026 at 3:42 PM, V17 (Restorative Nurse) stated it is expected that the splints and palm protectors are applied to the residents as ordered. V17 stated if they are not worn as ordered, residents can get a contracture or further decline to an existing contracture.\ On 05/07/26 at 1:43 PM, V27 (Licensed Practical Nurse) stated she received the order from the nurse practitioner for R113 to receive OT for a decrease in ADL's, trigger finger bilaterally. V27 stated she did not inform therapy of the order. V27 stated she never told the DON or ADON (Assistant Director of Nursing) about the order for OT. The facility's Managing Residents with Impaired Physical Mobility Policy, dated 06/20/2020, showed, Facility will provide care and management of physical mobility impairment based on cause and nature for deformity. Facility will provide programs to prevent contractures and or further decline. 2) Treatment of Contractures, a) Physical therapy and occupational therapy evaluation and treatment as indicated, b) Restorative program based on assessment, c) Medical devices. Supportive devices such as splints and casts may be applied to stretch the tissues of the affected body part based on therapy/MD (Medical Doctor) recommendations.

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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. Based on observation, interview, and record review, the facility failed to assess and care plan for a resident to ensure he is a safe smoker and failed to ensure the resident did not keep his smoking materials unsecured.This applies to 1 of 2 residents (R32) reviewed for smoking in a sample of 30.The findings include:R32's face sheet documents he was admitted to facility on 6/17/25. Diagnoses include atherosclerotic heart disease, type II diabetes mellitus, hyperlipidemia, dementia, chronic obstructive pulmonary disease, hypertension, major depressive disorder, anxiety disorder, and delusional disorder. MDS (Minimum Data Sheet), dated 4/12/26, shows he has intact cognitive functions and is independent with transfers.On 5/5/26 at 10:41 AM, R32 was sitting on his rolling walker; he had a pack of cigarettes and a lighter on his shirt pocket. Three more packs of cigarettes were on a shelf on top of his nightstand. R32 said he had more lighters in his blue bag. He said his girlfriend brought him cigarettes and lighters. A review of R32's EMR (Electronic Medical Record) on 5/5/26 at 1:00 PM shows R32 was never assessed for safe smoking since he was admitted and R32 did not have a care plan for smoking.On 5/7/26 at 1:30 AM, V6 (SSD-Social Service Director) said she was in charge of assessing residents for safe smoking and said she has never done an assessment for R32 since admission. She said assessment for safe smoking is done upon admission, quarterly and as needed to know if a resident can smoke independently or not. She said R32 should not have more than a pack of cigarettes in his room. He said smokers must turn all their cigarettes and lighters to the receptionist at the end of the day after the last smoking time at night.The facility provided a Smoker's Program care plan for R32, which was created on 5/6/26. Facility's Smoking Policy, dated 11/20/23, documents the following: Independent Smoking: Residents on the independent smoking program will have the opportunity to smoke between the hours of 7:00 AM to 7:00 PM. Independent smoking is a privilege that can be earned or taken away by compliance (or non-compliance) in the following area: Ability to safely put out and dispose of smoking materials in appropriate receptacles and return all cigarettes and lighters to the front desk immediately when returning. Every resident that is newly admitted or re-admitted to the facility will be assessed and monitored for safe and responsible smoking guidelines.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to check for G-tube (Gastrostomy Tube) placement before flushing the gastrostomy tube and before providing tube feeding. This applies to 2 out of 2 (R6, R13) residents reviewed for feeding tubes in a sample of 30.The findings include:1. R6's face sheet documents he was admitted to facility on 2/19/26. Diagnoses include pleural effusion, gastrostomy, acute and chronic respiratory failure with tracheostomy and dependent on ventilator, dysphagia, diabetes mellitus, atherosclerotic heart disease, and cachexia. MDS (Minimum Data Sheet), dated 3/26/26, documents he has intact cognitive functions and is dependent on staff for eating. R6's POS (Physician Order Sheet) shows order for G-Tube feeding order for Glucerna 1.5 at 80 ml per hour for 20 hours, on at 12:00 PM and off at 8:00 AM with G-Tube flush of 300 ml per hour every six hours. R6 also had an order for Ferrous Sulfate Oral Solution, give 220 mg via G-Tube three times a day. On 05/07/26 at 12:10 PM, V7 (RN-Registered Nurse) said she was starting R6's G-Tube feeding. She said she also has to administer Ferrous Sulfate before starting the feeding. V7 proceeded to set the flow rate as ordered and primed the tubing. V7 went back to her medication cart to get R6's medication. V7 then proceeded to flush the tubing with water, administered the medication, and hooked up and started the feeding. V7 did not check for placement of the G-Tube prior to administering the medication and feeding.R6?s care plan, created on 3/19/25 and revised on 4/28/26, shows R6 requires tube feeding related to dysphagia, swallowing problem, infection, weight loss and depression. Interventions included checking for tube placement, size of tube, and gastric contents/residual volume per facility protocol and record. 2. R13's face sheet documents she was admitted to the facility on [DATE]. Diagnoses include acute and chronic respiratory failure, chronic obstructive pulmonary disease, dementia, epilepsy, paraplegia, and presence of gastrostomy and tracheostomy. MDS dated [DATE] shows R13's Cognitive Patterns were not assessed and R13's eating ability was not applicable which means activity was not attempted and the resident did not perform this activity prior to current illness, exacerbation, or injury.R13's POS show order for G-Tube feeding of Jevity 1.5 at 60 ml per hour, on at 12:00 PM and off at 8:00 AM with G-Tube flush with 275 ml water every six hours.On 05/07/26 at 12:30 PM, R13's tube feeding machine was beeping. V7 went into R13's room. R13 had ongoing G-Tube feeding. V7 said the beeping sound means there is blockage and she needed to flush the tubing. V7 disconnected R13 from feeding machine and flushed R13's tubing with water. V7 then proceeded to set the flow rate as ordered and re-primed the tubing. V7 then re-started R13's feeding. V7 did not check for placement of G-Tube prior to flushing the tubing and re-starting feeding. R13's care plan, initiated on 4/7/26, shows R13 requires a feeding tube related to dysphagia. Intervention included checking tube placement and gastric contents/residual volume per facility protocol and record. On 5/7/26 at 12:45 PM, V7 said she forgot to check for G-Tube placement before flushing the tubing and before providing G-tube feeding. She said placement should be checked to prevent aspiration. On 5/7/26 at 1:30 PM, V2 (DON-Director of Nursing) said she expects all nurses to check for G-tube placement prior to flushing and feeding. She said not checking placement will put the resident at risk for aspiration.Facility's Policy titled Enteral Feeding Medication Administration, dated 1/20/21 and reviewed on 6/16/22, 6/15/23, 5/28/24, 4/18/25 and 4/15/26, documents: Procedure: Residents admitted to Facility With An Enteral Feeding Tube: 6. Prior to flushing of a feeding tube, the administration of medication via a feeding tube, or the providing of tube feedings, the nurse performing the procedure ensures the proper placement of the feeding tube by checking gastric aspirates/residual. Notify MD/NP if gastric residual exceeds 100 ml and above.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure the treatment dressing on a venous access device (VAD) site was in place for resident on dialysis, and failed to ensure the dressing replacement was completed in a sterile manner. This applies to 1 of 1 residents (R9) reviewed for dialysis.The findings include:On 5/5/26 at 12:21 PM, R9 said her main concern is the effectiveness of hemodialysis as her health has been up and down in the past year. R9 was observed without a dressing covering her left chest venous access device (VAD) that is used for hemodialysis and redness at the insertion site. R9 said she has a history of MRSA (Methicillin Resistant Staphylococcus Aureus) infection of her hemodialysis site and she recently had her site changed from her right chest to her left chest. R9's MDS (Minimum Data Set) dated 4/10/26 shows her cognition is intact. R9's Physician Orders showed an order dated 4/17/26 for in-house renal dialysis 3 times a week.On 5/5/26 at 12:31 PM, V4 (RN/Registered Nurse) said she did not know when R9's VAD dressing came off. At 12:35 PM, V4 entered R9's room without washing her hands or putting on gloves and pulled back the neck of R9's shirt to assess her VAD site with her bare hands. V4 then left R9's room to gather supplies to place a new dressing over the VAD site. While sitting on the side of her bed, R9 removed her left arm from her shirt and left it hanging by the left side of her neck. V4 returned to R9's room with sterile dressing change kit. While placing a new sterile dressing over R9's VAD site, the tag of R9's shirt touched the gauze covering the insertion site and instead of changing the gauze, V4 placed the clear dressing on top of the compromised gauze. V4 did not wear a gown during the VAD sterile dressing change. While cleansing the VAD site with the chlorhexidine swab, V4 cleansed in a rainbow motion (side to side) over the superior aspect of the VAD and did not cleanse the inferior aspect of the VAD site.On 5/6/26 at 1:34 PM, V5 (Hemodialysis RN) said R9 has come to hemodialysis on multiple occasions without a dressing covering her VAD hemodialysis site. V5 said R9 came to dialysis two days earlier on 5/4/26 without a dressing on her site. V5 said hemodialysis VAD sites should always have a dressing covering them, because if bacteria enters the body through the VAD site, there is a greater risk for infection, including infection of the heart, that could be deadly for the resident. V5 said dressing changes of hemodialysis sites require full PPE including a gown and the chlorhexidine swab should be wiped in a full circular motion starting at the VAD insertion site and moving outwards. On 5/7/26 at 2:18 PM, V2 (DON/Director of Nursing) said hemodialysis sites always need to be covered with a dressing to prevent infection. V2 said hemodialysis VAD sites pose a greater risk for infection if they are not properly dressed because the line goes directly into the blood stream and it ends close to the resident's heart. V2 said hemodialysis residents are already at risk for infection due to their impaired kidney function, and having a central line puts them at greater risk. V2 said the field needs to be kept sterile during hemodialysis site dressing change. The hemodialysis provided policy titled, Vascular Access Care for Dialysis Patients, with origination date 8/2025, states, Purpose: To establish safe, evidence-based procedures for the monitoring and care of vascular access in dialysis patients.This policy ensures patient safety, early detection of complications, and proper coordination of care with dialysis partners.Scope: Those policy applies to all.dialysis units across skilled nursing facilities and contracted sites. Policy:.Central Venous Catheter: Dressing Care: dressing must remain clean, dry, and intact at all times.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident was free from a significant medication error. This applies to 1 of 1 resident (R20) reviewed for significant medication errors in a sample size of 30. The findings include: R20 was admitted to the facility on [DATE] with multiple diagnoses which included dementia, diabetes, hypertension, and hyperlipidemia. The Order Summary Report for May 2026 showed Losartan 100 mg daily. The packing slip proof of delivery from the pharmacy showed on 04/08/26, the pharmacy delivered Losartan Pot tab 50 mg, quantity of 30. The MAR (Medication Administration Record) for May 2026 showed Losartan Potassium Oral Tablet 50 mg, give 100 mg by mouth one time a day for HTN (hypertension), start date 04/09/26. R20's altered cardiac function care plan date 02/27/26, showed Give antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate and effectiveness. Progress Notes dated 04/08/26 at 8:06 PM, showed, Patient seen today for follow up of hypertension. Blood pressure trends over the past several weeks reviewed. Readings have been variable ranging approximately from 110's to 160's systolic, with intermittent elevations in the 160's. Recent readings include 145/83, 158/101, 162/88, 154/74, and 140/72, demonstrating fluctuating control despite current regimen. Patient currently on multiple hypertensives including amlodipine, carvedilol, hydralazine, and losartan. Given persistent variability and intermittent elevations, losartan increased to 100 mg daily. Patient is at moderate to high risk for complications related to hypertension given variable blood pressure control requiring multi-drug therapy and recent medication adjustment.On 05/06/26 at 8:40 AM, V23 (LPN/Licensed Practical Nurse) prepared morning medications to be administered to R20. V23 placed one Losartan Pot 50 mg (milligram) tablet, one Amlodipine 10 mg tablet, one glipizide 5mg tablet, one Jardiance 10 mg tablet, and one Iron + Vitamin C 65-125mg tablet in a medication cup. Before V23 administered the medication to R20, V23 verified the total of pills. There was a total of five pills in the cup. During the medication reconciliation, the Order Summary Report Active Orders for May 2026 showed, Losartan Potassium Oral Tablet 50 mg, give 100 mg by mouth one time a day for hypertension. The label on the medication card showed Losartan Pot tablet 50 mg. Give one tablet by mouth daily for hypertension. The medication card had ten pills remaining after V23 administered the medication to R20. The medication room was checked by the surveyor and V23 to see if R20 had more Losartan. There was no extra Losartan for R20. On 05/07/26 at 9:58 AM, V2 (DON/Director of Nursing) stated the pharmacy delivered Losartan 50 mg, 30 tablets on 04/08/26. V2 stated R20's current orders are for Losartan 100 mg daily. V2 stated with the manifest from the pharmacy and the number of pills dispensed (30), R20 would not have any pills left if the nurses were administering Losartan 100 mg as ordered. V2 stated the nurses were only administering him Losartan 50 mgs daily as the card showed. V2 stated if the medications are not administered as ordered, R20's blood pressure could not be controlled. The facility's Medication Administration Policy, dated 03/20/2020, showed, All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. 5) Check medication administration record prior to administering medication for the right medication, dose, route, patient and time. 6) Read each order entirely. 8) If there is a discrepancy between the MAR and label, check orders before administering medications. 9) If the label is wrong, send medications to pharmacy for relabeling or call pharmacy to send a new label. If the MAR is wrong, reenter the order.

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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. Based on observation, interview, and record review, the facility failed to follow infection control and prevention practices with PPE (Personal Protective Equipment) usage.This applies to 2 residents (R9 and R1) reviewed for infection control in a sample of 30 residents.The findings include: 1.On 5/5/26 at 12:21 PM, R9 said her main concern is the effectiveness of hemodialysis as her health has been up and down in the past year. R9 was observed without a dressing covering her left chest venous access device (VAD) that is used for hemodialysis and redness at the insertion site. R9 said she has a history of MRSA (Methicillin Resistant Staphylococcus Aureus) infection of her hemodialysis site and she recently had her site changed from her right chest to her left chest. R9's MDS (Minimum Data Set) dated 4/10/26 shows her cognition is intact. There was EBP (Enhanced Barrier Precautions) signage outside room with PPE cart. On 5/5/26 at 12:35 PM, V4 (RN/Registered Nurse) entered R9's room without washing her hands or putting on gloves and pulled back the neck of R9's shirt to assess her VAD site with her bare hands. V4 then left R9's room to gather supplies to place a new dressing. V4 did not wear a gown during the VAD sterile dressing change. On 5/6/26 at 1:34 PM, V5 (Hemodialysis RN) V5 said dressing changes of hemodialysis sites require full PPE, including a gown. On 5/7/26 at 2:18 PM, V2 (DON/Director of Nursing) stated the nurse needs to wear full PPE including a gown to prevent bacteria growth and central line infection. R9's Face sheet shows the following diagnoses: end stage renal disease, dependence on renal dialysis, complication of vascular dialysis catheter, and personal history of methicillin resistant staphylococcus aureus (MRSA) infection. Order dated 5/1/26 reads vancomycin 1250mg/250mL (milligrams/milliliter) intravenously every Monday, Wednesday, and Friday for infection. R9's Physician Order Sheet showed an order dated 4/12/26 for enhanced barrier precaution. R9's Care Plan last revised 12/9/24 states resident is on enhanced barrier precautions related to indwelling dialysis device. Interventions include: clean and wash hands before entering and when leaving resident's room, and wear gloves and gown for high contact resident care activities, including central line device care. Care Plan created 5/1/25 states resident has MRSA requiring contact isolation of dialysis site. 2. R1's face sheet document admission date of 4/9/26. Diagnoses include hemiplegia, type II diabetes mellitus, cerebral infarction, chronic respiratory failure, encephalopathy, dysphagia, hypertension, hyperlipidemia, anemia, presence of tracheostomy and presence of gastrostomy. MDS (Minimum Data Sheet) dated 4/13/26 documents she has moderate cognitive impairment and is totally dependent on staff for ADLs (Activities of Daily Living) and transfers. R1 is on contact isolation due to presence of tracheostomy. On 5/6/26 at 11:10 AM, V12 (R1's family member) was seen inside R1's room, sitting on a chair on the right side of R1's bed. He was not wearing any surgical mask, gown or glove. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/26 at 11:15 AM, R4 (RN- Registered Nurse) said visitors entering rooms with the Contact Isolation sign must wear gowns, gloves and surgical mask to protect the resident from infection because they come from the outside and might unknowingly be a carrier of infection. She said she did not educate V12 on use of proper PPE (Personal Protective Equipment) before he entered R1's room. On 5/6/26 at 1:14 PM, V8 (IP-Infection Preventionist) said all residents with tracheostomy are on contact isolation due to history of MDRO (Multidrug Resistant Organism) and to protect them from infection. V8 said visitors must also wear gowns, gloves and mask when entering a room on contact isolation to protect the resident from infection. She said R1 is currently on antibiotics for a urinary tract infection and positive sputum culture. R1's POS (Physician Order Sheet) documents she is currently receiving Cefuroxime Axetil oral tablet 500 mg , 1 tablet via G-tube every 12 hours for positive sputum culture for Proteus Mirablis for 7 days and Meropenem Intravenous Solution Reconstituted 1 GM, use 1 gm IV every 8 hours for UTI (Urinary Tract Infection)- Escherichia Coli and Proteus Mirabilis in sputum culture for 7 days . Both medications were started on 5/4/26. Facility's Policy titled Isolation- Categories of Transmission- Based Precautions dated 11/23/21 and reviewed on 6/2/22, 5/31/23, 5/31/24, 5/31/25 and 1/14/26 documents 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. b. Staff and visitors will wear gloves (clean, non-sterile) when entering the room. 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 gown is removed.