STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark-Lindsey Village	101 West Windsor Road Urbana, IL 61801

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents rights were honored for one (R1) resident out of five residents reviewed for Resident Rights in a sample list of eight residents.Findings include: R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. This same MDS documents R1 as requiring set up assistance with eating, oral hygiene, is dependent on staff for assistance with dressing and requires moderate assistance for bed mobility and transfers.R1's Care Plan initiated does not include a focus area, goal nor interventions for R1's resident's right to make her own choices. On 10/15/25 at 9:47 AM, R1 was laying in her bed with her breakfast tray of food sitting on her bedside table. R1 stated she just finished her breakfast. R1 stated she prefers to get up out of bed 'much earlier around 7:00 AM' to eat her breakfast in the dining room. R1 stated she enjoys talking with the other residents. R1 stated she was told by the facility staff that the facility was 'short staffed' today and did not have enough staff to get her up earlier. R1 stated The girls (staff) work hard and I understand that they are trying but I would like to get up to the dining room table for all of my meals. I don't mind this once in a while, but it has recently become the norm to have me eat breakfast in bed because of low staffing.On 10/15/25 at 10:00 AM, V19 (Certified Nursing Assistant/CNA) stated the facility did not have enough staff this morning (10/15/25) to get all the residents out of bed and out to the dining room for breakfast. V19 stated there are multiple residents who would normally go to the dining room but just can't due to lack of staff. V19 stated there are plenty of 'bodies' but those extra staff do not provide cares for staff. V19 stated the residents should be able to go to the dining room if they choose to. On 10/15/25 at 11:30 AM, V2 (Interim Director of Nurses/DON) stated the facility does provide more than the regulatory requirement of staff to provide cares for the residents. V2 stated the residents should be provided the cares as requested and/or needed without question. V2 stated she was aware of staffing concerns on R2's hall this morning (10/15), but the ancillary licensed staff (V20 Health Services Administrative Coordinator/CNA) was on the hall. V2 stated she will in-service (V20) ancillary staff to ensure resident care takes priority. V2 stated R1 should have been assisted up to the dining room for breakfast if that is what R2 prefers. The State Agency pamphlet dated April 2024 documents the facility must make reasonable arrangements to meet your needs and choices.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to document, follow up and resolve grievances for one (R7) resident out of five residents reviewed for grievances in a sample list of eight residents. Findings include: R7's Minimum Data Set (MDS) dated [DATE] documents R7 as moderately cognitively impaired. This same MDS documents R7 requires maximum assistance from staff for personal hygiene and is completely dependent on staff for assistance with eating, oral hygiene, toileting, showering, dressing, bed mobility and transfers. On 10/14/25 at 8:30 AM, during the entrance conference, V2 (Interim Director of Nurses/DON) stated the facility has not had any family concerns and/or grievances for the past three months. V2 stated there is no grievance log or grievance reports. On 10/14/25 at 10:20 AM, V16 (R7's Power of Attorney/POA) stated on 9/7/25, V10 and V11 (Certified Nurse Assistants/CNAs) assisted R7 to R7's bathroom toilet. V16 stated R7 was being transported from her bed to the toilet using a total body mechanical lift using a toilet sling. V16 stated during the transport back from the toilet to the bed, R7 continued to have a bowel movement. V16 stated R7 was not positioned correctly in the sling and was 'screaming in pain'. V16 stated R7 was about a foot away from the toilet. V16 stated V11 (CNA) then pushed a small garbage can under R7. V16 stated R7 was forced to have a bowel movement in a garbage can as she was screaming in pain due to poor positioning. V16 stated V16 has had multiple conversations and ongoing electronic mail (E-mail) with V2 (Interim DON). V16 stated V16 asked V2 to not have V10 and V11 CNAs in R7's room and/or providing any cares for R7 after the 9/7/25 incident. V16 stated both V10 and V11 have provided cares since that date (9/7) and when V2 was informed, V2 responded with '(V10, V11) are not (R7's) primary CNAs so that is okay'. V16 stated she asked if there was someone else to speak to about ongoing care concerns and the staff 'neglecting' R7 and was told by V2 that no one else would be able to do anything. On 10/14/25 at 1:20 PM, V1 (Administrator in Training/AIT) stated she was made aware of R7's family concerns on 9/7/25. V1 stated V2 (Interim DON) informed V1 that V2 is 'taking care of that situation' and nothing else needed to be discussed and/or elevated to a grievance report. On 10/14/25 at 2:20 PM, V2 (Interim DON) stated V2 has worked 'closely' with V16 (R7's POA). V2 stated V16 has had multiple concerns about the lack of care for R7. V2 stated V16's concerns were never reported to V21 (Grievance Officer) due to V2 did not think V16's concerns needed to 'rise to the level of a grievance'. On 10/15/25 at 12:05 PM, V21 (Grievance Officer) stated grievances can be brought forward from residents, resident representatives, staff, visitors or anyone who has a grievance. V21 stated she has not received nor been made aware of V16 (R7's POA) concerns. V21 stated V16's concerns would 'rise to the level of a grievance' and should have been brought forward.The facility policy dated October 19, 2022, titled Grievance Policy documents It is the policy of this facility that each resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their facility stay. Voicing grievances is not limited to a formal, written grievance process but may include a resident's verbalized complaint to facility staff.

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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 0600 Level of Harm - 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect one (R7) resident's right to be free from abuse and neglect by staff members (V10, V11) out of five residents reviewed for abuse and neglect in a sample list of eight residents. R7 was not provided basic cares such as repositioning and incontinence care timely. R7 was made to cry, scream and yell out in pain as staff refused to assist and reposition R7 during incontinent cares. Findings include:R7's Electronic Medical Record documents medical diagnoses as Gastrointestinal Hemorrhage, Protein-Calorie Malnutrition, Alzheimer's Disease, Dementia, Anxiety, Difficulty in Walking, Need for Assistance with Personal Cares, Cognitive Communication Deficit, Crohn's Disease, Cervical Disc Degeneration, Diverticulitis of Large Intestine, Diabetes Mellitus Type II, Dysphagia, Unsteady on Feet and Repeated Falls.R7's Minimum Data Set (MDS) dated [DATE] documents R7 as moderately cognitively impaired. This same MDS documents R7 requires maximum assistance from staff for personal hygiene and is completely dependent on staff for assistance with eating, oral hygiene, toileting, showering, dressing, bed mobility and transfers. R7's Care Plan interventions dated 7/15/25 instructs the staff to anticipate and meet R7's needs and encourage frequent position changes as condition allows.On 10/14/25 at 10:10 AM, V16 (R7's Power of Attorney/POA) stated the facility is ‘short-staffed'. V16 stated R7 has to wait 30-60 minutes sometimes for staff to answer the call light. V16 stated R7 has cameras placed in her room that record 24 hours per day. V16 stated the personal cameras are reviewed daily and ‘many times' sees that staff do not enter R7's room for multiple hours at a time. V16 stated R7 is incontinent of urine and bowel and needs to be ‘at least changed' (provided incontinence care) every two hours. V16 stated on 9/7/25 V10 and V11 Certified Nursing Assistants/CNAs) assisted R7 to R7's bathroom toilet. V16 stated R7 was being transported from her bed to the toilet using a total body mechanical lift using a toilet sling. V16 stated during the transport back from the toilet to the bed, R7 continued to have a bowel movement. V16 stated R7 was not positioned correctly in the sling and was ‘screaming in pain'. V16 stated R7's entire buttocks and hips were showing below the sling and both of R7's arms were forced above her head due to R7 was sliding out of her sling. V16 stated R7 was about a foot away from the toilet. V16 stated she yelled at the staff (V10, V11) to assist R7 back on the toilet to readjust R7's sling, reduce R7's pain and allow R7 to finish having her bowel movement. V16 stated V11 (CNA) yelled at V16 to ‘get away from us', ‘you need to go sit down' and ‘we (V10, V11) are not moving (R7) anywhere, we know what we are doing, now go sit down'. V16 stated V11 (CNA) then pushed a small garbage can under R7. V16 stated R7 was forced to have a bowel movement in a garbage can as she was screaming in pain due to poor positioning. V16 stated R7 would think this would be ‘absolutely horrid' and be ‘humiliating' to have to have a bowel movement in a garbage can. V16 stated R7 would never have a bowel movement in a garbage can and would be ‘mortified' at this entire incident. V16 stated R7 was ‘hysterical' and ‘afraid' during this transfer back to her bed due to R7 was afraid she was going to fall and was in so much pain. V16 stated V10 and V11 CNAs left R7 on her bed without finishing incontinence care or positioning R7 safely in bed. V16 stated They (V10, V11) just left (R7) there with p*** (expletive) on her. They (V10, V11) walked out of the room and did not come back. V16 stated the facility ‘neglected' R7 by not providing perineal and/or incontinence care, not repositioning R7 for extended periods of time and refused to provide pain relief by not transferring R7 as V16 requested the staff to move R7 to a more comfortable position. V16 stated the staff are ‘belligerent and confrontational' when V16 asked for assistance. V16 stated V15, V17 (R7's private caregivers) and V16 provide direct cares, repositioning, feeding assistance and administer medications to R7 due to the staff are ‘neglectful' by not entering R7's room and force R7's family and caregivers to provide all of the services themselves. V16 stated We (V15, V16, V17) have to do everything for (R7). We (V15, V16, V17) provide all the cares, we administer all of her medications, we reposition (R7), we feed (R7), we provide oral care, nail care, skin care, etc. for (R7). We have to do everything because the staff neglect (R7) on a daily basis. We turn on the call light and no one comes for hours. We have cameras in (R7's) room that shows NO staff enter for six or eight hours or more. Anything (R7) needs, we (V15, V16, V17) have to go get and bring to (R7's) room. We even have to go get her medications because the nurses won't bring them. V16 stated the facility provided packets and a gallon jug of thickener and a device for V15, V16 and V17 to crush R7's medications. V16 stated the facility allows the staff to neglect R7 by knowing that the staff are not providing R7's cares. V16 stated V16 has had multiple conversations and ongoing electronic mail (E-mail) with V2 (Interim Director of Nursing/DON). V16

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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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of neglect for one (R7) resident out of five residents reviewed for Abuse in a sample list of eight residents. Findings include:R7's Minimum Data Set (MDS) dated [DATE] documents R7 as moderately cognitively impaired. This same MDS documents R7 requires maximum assistance from staff for personal hygiene and is completely dependent on staff for assistance with eating, oral hygiene, toileting, showering, dressing, bed mobility and transfers. The facility is unable to provide documentation of R7's allegation of abuse/neglect on 9/7/25 as being reported to the State Surveying Agency. On 10/14/25 at 10:10 AM, V16 (R7's Power of Attorney/POA) stated the facility is 'short-staffed'. V16 stated R7 has to wait 30-60 minutes sometimes for staff to answer the call light. V16 stated R7 has cameras placed in her room that record 24 hours per day. V16 stated the personal cameras are reviewed daily and 'many times' sees that staff do not enter R7's room for multiple hours at a time. V16 stated R7 is incontinent of urine and bowel and needs to be 'at least changed' (provided incontinence care) every two hours. V16 stated on 9/7/25 V10 and V11 Certified Nursing Assistants/CNAs) assisted R7 to R7's bathroom toilet. V16 stated R7 was being transported from her bed to the toilet using a total body mechanical lift using a toilet sling. V16 stated during the transport back from the toilet to the bed, R7 continued to have a bowel movement. V16 stated R7 was not positioned correctly in the sling and was 'screaming in pain'. V16 stated R7's entire buttocks and hips were showing below the sling and both of R7's arms were forced above her head due to R7 was sliding out of her sling. V16 stated R7 was about a foot away from the toilet. V16 stated she yelled at the staff (V10, V11) to assist R7 back on the toilet to readjust R7's sling, reduce R7's pain and allow R7 to finish having her bowel movement. V16 stated V11 (CNA) yelled at V16 to 'get away from us', 'you need to go sit down' and 'we (V10, V11) are not moving (R7) anywhere, we know what we are doing, now go sit down'. V16 stated V11 (CNA) then pushed a small garbage can under R7. V16 stated R7 was forced to have a bowel movement in a garbage can as she was screaming in pain due to poor positioning. V16 stated R7 would think this would be 'absolutely horrid' and be 'humiliating' to have to have a bowel movement in a garbage can. V16 stated R7 would never have a bowel movement in a garbage can and would be 'mortified' at this entire incident. V16 stated R7 was 'hysterical' and 'afraid' during this transfer back to her bed due to R7 was afraid she was going to fall and was in so much pain. V16 stated V10 and V11 CNAs left R7 on her bed without finishing incontinence care or positioning R7 safely in bed. V16 stated They (V10, V11) just left (R7) there with p*** (expletive) on her. They (V10, V11) walked out of the room and did not come back. V16 stated the facility 'neglected' R7 by not providing perineal and/or incontinence care, not repositioning R7 for extended periods of time and refused to provide pain relief by not transferring R7 as V16 requested the staff to move R7 to a more comfortable position. V16 stated the staff are 'belligerent and confrontational' when V16 asked for assistance. V16 stated V15, V17 (R7's private caregivers) and V16 provide direct cares, repositioning, feeding assistance and administer medications to R7 due to the staff are 'neglectful' by not entering R7's room and force R7's family and caregivers to provide all of the services themselves. V16 stated We (V15, V16, V17) have to do everything for (R7). We (V15, V16, V17) provide all the cares, we administer all of her medications, we reposition (R7), we feed (R7), we provide oral care, nail care, skin care, etc. for (R7). We have to do everything because the staff neglect (R7) on a daily basis. We turn on the call light and no one comes for hours. We have cameras in (R7's) room that shows NO staff enter for six or eight hours or more. Anything (R7) needs, we (V15, V16, V17) have to go get and bring to (R7's) room. We even have to go get her medications because the nurses won't bring them. V16 stated the facility provided packets and a gallon jug of thickener and a device for V15, V16 and V17 to crush R7's medications. V16 stated the facility allows the staff to neglect R7 by knowing that the staff are not providing R7's cares. V16 stated V16 has had multiple conversations and ongoing electronic mail (E-mail) with V2 (Interim Director of Nursing/DON). V16 stated V16 asked V2 to not have V10 and V11 (CNAs) in R7's room and/or providing any cares for R7 after the 9/7/25 incident. V16 stated both V10 and V11 have provided cares since that date (9/7) and when V2 was informed, V2 responded with '(V10, V11) are not (R7's) primary CNAs so that is okay'. V16 stated she asked if there was someone else to speak to about ongoing care concerns and the staff 'neglecting' R7 and was told by V2 that no one else would be able to do anything. On 10/14/25 at 1:20 PM, V1 (Administrator in Training/AIT) stated she was made aware of R7's family concerns on 9/7/25. V1 stated V2 (Interim Director of Nursing/DON) informed V1 that V2 is 'taking care of that situation' and nothing

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to investigate an allegation of neglect for one (R7) resident out of five residents reviewed for Abuse in a sample list of eight residents. Findings include: R7's Minimum Data Set (MDS) dated [DATE] documents R7 as moderately cognitively impaired. This same MDS documents R7 requires maximum assistance from staff for personal hygiene and is completely dependent on staff for assistance with eating, oral hygiene, toileting, showering, dressing, bed mobility and transfers. The facility is unable to provide documentation of R7's allegation of Abuse/neglect on 9/7/25 as investigated by the facility. On 10/14/25 at 10:10 AM, V16 (R7's Power of Attorney/POA) stated the facility is 'short-staffed'. V16 stated R7 has to wait 30-60 minutes sometimes for staff to answer the call light. V16 stated R7 has cameras placed in her room that record 24 hours per day. V16 stated the personal cameras are reviewed daily and 'many times' sees that staff do not enter R7's room for multiple hours at a time. V16 stated R7 is incontinent of urine and bowel and needs to be 'at least changed' (provided incontinence care) every two hours. V16 stated on 9/7/25 V10 and V11 Certified Nursing Assistants/CNAs) assisted R7 to R7's bathroom toilet. V16 stated R7 was being transported from her bed to the toilet using a total body mechanical lift using a toilet sling. V16 stated during the transport back from the toilet to the bed, R7 continued to have a bowel movement. V16 stated R7 was not positioned correctly in the sling and was 'screaming in pain'. V16 stated R7's entire buttocks and hips were showing below the sling and both of R7's arms were forced above her head due to R7 was sliding out of her sling. 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V16 stated V16 asked V2 to not have V10 and V11 (CNAs) in R7's room and/or providing any cares for R7 after the 9/7/25 incident. V16 stated both V10 and V11 have provided cares since that date (9/7) and when V2 was informed, V2 responded with '(V10, V11) are not (R7's) primary CNAs so that is okay'. V16 stated she asked if there was someone else to speak to about ongoing care concerns and the staff 'neglecting' R7 and was told by V2 that no one else would be able to do anything. On 10/14/25 at 10:20 AM, V16 (R7's Power of Attorney/POA) stated she emailed V2 (Interim Director of Nursing/DON) on 9/7/25 following a 'terrible incident' between V10 and V11 (Certified Nursing Assistants/CNAs) and R7. V16 stated V2 responded in

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark-Lindsey Village	101 West Windsor Road Urbana, IL 61801

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide Licensed Nurses to administer medications on multiple occasions for one (R7) resident out of five residents reviewed for Improper Nursing Care in a sample list of eight residents.Findings include:R7's Minimum Data Set (MDS) dated [DATE] documents R7 as moderately cognitively impaired. This same MDS documents R7 requires maximum assistance from staff for personal hygiene and is completely dependent on staff for assistance with eating, oral hygiene, toileting, showering, dressing, bed mobility and transfers. R7's Physician Order Sheet (POS) dated October 2025 documents physician orders to administer:-Cephalexin 250 milligrams (mg)/5 milliliters (ml) starting 9/26/25 with no end date, give daily for recurrent Urinary Tract Infections (UTI). Prophylaxis for one year.-Cholecalciferol 25 micrograms (mcg). Give two tablets daily.-Lactobacillus Rhamnoses give one capsule daily.-Fluconazole 150 mg tablet daily for Vaginal Candidiasis every three days.-Fluoxetine 10 mg tablet daily-Benefiber packet daily-Lisinopril 40 mg tablet twice daily-Pantoprazole 4 mg/ml suspension give 10 ml daily-Polyethylene Glycol (Miralax) powder 8.5 Grams daily-Prednisone 5 mg tablet daily-Prozac 20 mg tablet daily-Zyrtec 10 mg tablet daily-Acetaminophen 1000 mg tablets twice daily-Carvedilol 12.5 mg tablet twice daily-Diclofenac Sodium 1% external gel. Apply to Left Ankle twice daily.-Lidocaine 5% External patch. Apply to neck in the morning, remove at night.-Memantine 5 mg tablet twice daily-Miconazole Nitrate powder 2%. Apply to vaginal area twice daily.-Potassium Chloride 20 milli equivalents (mEq)/15 ml liquid. Give 15 ml twice daily.On 10/14/25 at 11:10 AM, V15 (R7's private caregiver) left R7's room and returned at 11:20 AM with a medicine cup of a small amount of off-white colored liquid. V15 added 15 milliliters (ml) of liquid thickener that was on R7's bedside dresser, placed the mixture in a syringe and administered R7's Pantoprazole by placing the syringe in R7's Left Buccal area and pushing the syringe so that the medicine was forced into R7's mouth. R7 coughed two times as a small amount of the mixture leaked out of the Left side of R7's mouth. V15 used a tissue to wipe away the medication. R7 had two adaptive cups with lids sitting on her bedside table. There were no medication labels on either cup. V15 stated one of the cups has R7's Miralax and the other cup has R7's Benefiber. V15 stated the nurses tell V15 and the caregivers (V10 and V11) that they do not have time to wait for R7 to take her medications, so they give them to V15 and/or private unlicensed caregivers. V15 stated V15 and private caregivers ‘have to do it this way or (R7) would not get her medications'. On 10/14/25 at 11:20 AM, V15 (R7's private caregiver) stated she is not a Licensed Nurse, does not work for the facility and has had no official training on how to administer medication, how much thickener to use, what the medication side effects are and what medication interactions may be. V15 stated V12 (Registered Nurse/RN) gave her R7's Pantoprazole at the nurse's station. V15 stated this is a daily occurrence because V15 has been told by ‘many' nurses that they (staff) do not have the time to stand and wait on R7 to take her medications due to R7 is a ‘slow swallower'.On 10/14/25 at 12:00 PM, V12 (RN) stated V12 provides medications to V16 (R7's POA) and/or V15 and V17 (R7's private caregivers) so that they (V15, V16, V17) can administer R7's medications. V12 RN stated she gave V15 all R7's medications for 10/14/25 for R7's morning scheduled medications including Benefiber and Miralax as well as R7's scheduled noon medication of Pantoprazole. V12 stated she prepares the medications and the ‘family/caregivers' administer the medications. V12 stated she does not observe R7's POA and/or private caregivers administer R7's medications. V12 stated she was instructed to provide R7's medications to V16 (R7's POA) and/or caregivers by other nurses. V12 stated This is how we (staff) all do it. Our administration approves of this, so I guess it is ok. V12 stated she is not aware if V15, V16 and/or V17 has any medical knowledge regarding medication administration. On 10/14/25 at 2:25 PM, V2 (Interim Director of Nurses/DON) stated V2 gave approval for V16 (R7's POA) to administer R7's medications without a nurse being present. V2 confirmed V16 and/or V15, V17 (R7) private caregivers are not licensed nurses and are not employed by the facility. On 10/14/25 at 2:50 PM, R7's Benefiber and Miralax were still in the cups sitting on R7's bedside table. The gallon jug of thickener, packets of thickener and pill crusher were still sitting on R7's bedside dresser. V17 (R7's private caregiver) stated R7's Benefiber was ‘stone thick' because it had been sitting too long. V17 stated she administers R7's medications daily and has done so for ‘months'. V17 stated the facility management gave R7's private caregivers and V16 (Power of Attorney/POA) approval to administer R7's medications. V17 stated she is not a licensed nurse and has never had any formal training on medication administration. V16 (R7's) Power of Attorney (POA) stated V20 (Health Services Administration Coordinator)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain accurate medical records for one (R7) resident out of five residents reviewed for Improper Nursing Care in a sample list of eight residents.Findings include: R7's Minimum Data Set (MDS) dated [DATE] documents R7 as moderately cognitively impaired. This same MDS documents R7 requires maximum assistance from staff for personal hygiene and is completely dependent on staff for assistance with eating, oral hygiene, toileting, showering, dressing, bed mobility and transfers. R7's Physician Order Sheet (POS) dated October 2025 documents physician orders to administer:-Cephalexin 250 milligrams (mg)/5 milliliters (ml) starting 9/26/25 with no end date, give daily for recurrent Urinary Tract Infections (UTI). Prophylaxis for one year.-Cholecalciferol 25 micrograms (mcg). Give two tablets daily. -Lactobacillus Rhamnoses give one capsule daily.-Fluconazole 150 mg tablet daily for Vaginal Candidiasis every three days.-Fluoxetine 10 mg tablet daily-Benefiber packet daily-Lisinopril 40 mg tablet twice daily-Pantoprazole 4 mg/ml suspension give 10 ml daily-Polyethylene Glycol (Miralax) powder 8.5 Grams daily-Prednisone 5 mg tablet daily-Prozac 20 mg tablet daily-Zyrtec 10 mg tablet daily-Acetaminophen 1000 mg tablets twice daily-Carvedilol 12.5 mg tablet twice daily-Diclofenac Sodium 1% external gel. Apply to Left Ankle twice daily.-Lidocaine 5% External patch. Apply to neck in the morning, remove at night.-Memantine 5 mg tablet twice daily-Miconazole Nitrate powder 2%. Apply to vaginal area twice daily.-Potassium Chloride 20 milli equivalents (mEq)/15 ml liquid. Give 15 ml twice daily.R7's Medication Administration Record (MAR) dated October 2025 documents V12 (Registered Nurse/RN) and V6 (Licensed Practical Nurse/LPN) administered R7's scheduled daily, and twice daily medications as ordered by the physician. On 10/14/25 at 12:00 PM, V12 (RN) stated V12 signs out medications for R7 that she does not administer. V12 stated she gives R7's medications to V16 (R7's Power of Attorney/POA) and/or R7's private caregivers to administer R7's medications. V12 stated she cannot confirm that R7 receives her medications prior to V12 signing out on R7's MAR as being given. On 10/15/25 at 10:05 AM, V6 (LPN) stated she gives all R7's medications to R7's private caregivers and/or V16 (R7's POA). V6 stated she signs out R7's MAR that R7's medications are being given because she 'trusts the family to give the meds so I don't have to waste my time doing it'. On 10/15/25 at 4:15 PM, V2 (Interim Director of Nurses/DON) stated the staff should document all the work they do. V2 stated nurses should ensure the resident is receiving the prescribed medications prior to signing off that the medication has been administered. The facility policy dated June 17, 2025, titled General Guidelines for Medication Administration documents the facility nurse should return to the medication cart and document medication administration with documentation in the Medication Administration Record (MAR) immediately after administering medication to each resident. Medications will be administered by legally authorized and trained persons in accordance with applicable State, Local and Federal laws and consistent with accepted standards of practice.