STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145404	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farmington Village Nrsg	701 South Main Street Farmington, IL 61531

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 accurately assess a resident for elopement risk, ensure adequate supervision, and develop and implement interventions to prevent a resident from eloping on multiple occasions for one of twenty-four residents (R65) reviewed for elopement in the sample of 64. These failures resulted in R65 exiting the building unsupervised on multiple occasions, creating a likelihood of serious injury, harm, or death and put R65 at risk for suffering falls with major injury, weather exposure, and getting lost without the ability to summon help.The Immediate Jeopardy began on 11/12/25 when R65 was inaccurately assessed as being at zero risk for elopement despite documented elopement-risk behaviors. V1/Administrator and V2/Director of Nursing were notified of the Immediate Jeopardy on 4/24/26 at 12:00 PM. The surveyor confirmed by observation, interview, and record review the Immediate Jeopardy was removed on 4/28/26 but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the plan of corrections.Findings include:The facility's policy titled, Wandering, Unsafe Resident, dated 1/1/2016, documents, Purpose: The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. Policy Interpretation and Implementation: 1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement.) 2. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. 3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as detailed monitoring plan will be included. 4. A missing resident is considered a facility-wide emergency. If a resident is missing, the elopement/missing resident emergency procedure will be initiated: a. Determine if the resident is out on an authorized leave or pass; b. if the resident was not authorized to leave, initiate a search of the building(s) and premises; c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.; d. Provide search teams with resident identification information; and e. Initiate an extensive search of the entire area. 5. When resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Contact the Attending Physician and report findings and conditions of the resident; c. Notify the resident's legal representative (sponsor); d. Notify search teams the resident has been located; e. Complete and file an incident report; f. Document relevant information in the resident's medical record.The facility's policy titled, Elopements, dated 1/1/2016, documents, Purpose: Staff shall investigate and report all cases of missing residents. Policy Interpretation and Implementation: 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. 2. If an employee observes a resident leaving the premises, he/she should: a. Attempt to prevent the departure in a courteous manner; b. Get help from other staff members in the immediate vicinity, if necessary; and c. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises. 3. When a departing individual (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	return to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Notify the Attending Physician; c. Notify the resident's legal representative (sponsor) of the incident; d. Complete the file Report of Incident/Accident; and e. Document the event in the resident's medical record. 4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on an authorized leave or pass; b. If the resident was not authorized to leave, initiate a search of the building(s) and premises; c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e. Emergency Management, Rescue Squads, etc.); d. provide search teams with resident identification information; and e. Initiate an extensive search of the surrounding area. 5. When resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Contact the Attending Physician and report findings and conditions of the resident; c. Notify the resident's legal representative (sponsor); d. Notify search teams the resident has been located; e. Complete and file an incident report; f. Document relevant information in the resident's medical record.On 4/21/26 at 12:25 PM, R65 was getting up from his chair in the dining room with his lunch tray, walking at a fast pace, and was noticeably confused. V25/Certified Nursing Assistant (CNA) tried to verbally redirect R65 as he continued to walk past her towards the kitchen. V25 stated R65 just does what he wants.Throughout the survey from 4/21/26 through 4/23/26 between the hours of 8:30 AM and 3:30 PM, the facility's front entrance doors were unlocked, and no alarm system was activated.On 4/24/26 at 9:43 AM, V11/Staff Educator, whose office faces the front with a window, stated she usually leaves the facility at 2:00-2:30 PM and no one is in the front office after 4:00 PM. V11 confirmed the front door remains unlocked throughout the day and does not get locked until 8:00 PM.On 4/24/26 at 11:59 AM, V1/Administrator stated the front office staff monitor the front entrance doors. We used to have an employee that sat by the door to monitor it since the door is unlocked and unalarmed during the day, but that employee left a few weeks ago and we haven't been able to hire anyone for the position yet.R65's face sheet, dated 4/24/26, documents medical diagnoses including dementia, depression, bipolar disorder, and falls.R65's fall risk assessments, dated 7/1/2025, 10/1/25, 11/12/25, 12/30/25, and 3/23/26, document R65 is at high risk for falls.R65's quarterly BIMS (Brief Interview for Mental Status) assessments, dated 10/1/25, 12/30/25, and 3/24/26, document R65 has moderate cognitive impairment.R65's MDS (Minimum Data Set) assessment, dated 3/26/26, documents R65 can walk 150 feet independently.R65's elopement risk assessments completed and signed by V13/Social Services Director, dated 6/27/2025 and 10/1/25, show R65 was at high risk for elopement based on scores of 4.0 and 4.0. V13 documented ?Yes' to the following assessment items: Does the resident have any of the following: Alzheimer's, Traumatic Brain Injury, Dementia, or Serious Mental Illness; Does the resident exhibit any memory problems, including memory recall issues or indicators of delirium; Is the resident able to ambulate independently; Since the last review, has the resident exhibited any exit-seeking behaviors; V13 also documented on the 10/1/25 assessment, New wander guard (electronic wandering device) ordered under the assessment item to identify exit-seeking behaviors; however, V13 then documented ?No' to the assessment item asking if a monitoring device was placed.R65's progress note, dated 10/30/25 at 8:39 PM entered by V14/ Licensed Practical Nurse (LPN), documents R65 is alert with some confusion and is independent in facility. R65 has lapses in safety awareness, wanders, and requires redirection. He gets restless when he is unable to leave the facility.R65's progress note, dated 11/1/25 at 9:27 AM entered by V28/RN, documents R65 is alert with confusion and frequently wanders, requiring redirection from staff.R65's elopement risk assessment/observation, dated 11/12/25 and completed by V28/Registered Nurse (RN), documents R65 was assessed as zero risk for elopement. V28 documented R65's reason for placement to the facility as dementia care and R65 has moderately impaired decision-decisions poor with cues and supervision required for decision making. This same assessment documents R65 is independent with mobility/walking in room, walking (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in the corridor, and for locomotion on and off the unit. Under the Contributing Factors section, V28 did not check the boxes which would indicate the following: elopement attempts in the past that were successful or unsuccessful, removing device (electronic wandering device), resisting redirection from staff, wandering with no rational purpose/attempting to open doors, or wandering in the past 60 days. V28 also documented interventions were not necessary, R65 does not present an elopement risk, and no preventative actions were taken.On 4/24/26 at 11:00 AM, V28/RN stated R65's elopement risk assessment/observation completed by V28 on 11/12/25 was not accurate and should have reflected R65's elopement-risk behaviors. V28 confirmed if the assessment items would have been answered correctly indicated by checking the assessment items that applied to R65 such as wandering, resisting redirection, history of leaving the facility, previous elopements attempts, successful elopements, and marking ?Yes' to R65 presenting as an elopement risk, then R65 would have been identified as at risk for elopement by the assessment and care plan and interventions to address R65's elopement risk would have been triggered.R65's progress note, dated 12/4/25 at 6:34 PM entered by V30 LPN, documents R65 is receiving daily skilled nursing services for assessment and management related to the diagnoses of left knee, pain, wounds, bruises, confusion, safety awareness, and cognition. R65 is alert with confusion and forgetfulness, able to make needs known, and needs frequent reminders when he attempts to go outside. R65's cognition, safety boundaries, and awareness are poor.R65's progress note, dated 12/17/25 at 9:36 PM entered by V30/LPN, documents R65 receives daily skilled nursing services for assessment and management related to diagnoses of osteoarthritis of the left knee, pain, wounds and bruises, confusion, and safety awareness and cognition. R65 is alert with confusion and forgetfulness and needs frequent reminders when R65 attempts to go outside. R65's cognition and safety boundaries/awareness are poor.R65's elopement risk assessment, dated 12/30/25, document R65 scored a 2.0, indicating R65 was not at risk for elopement, and no care plan or interventions were required.R65's progress note, dated 1/5/26 at 9:25 AM entered by V28/RN, documents R65 is receiving skilled care related to his diagnoses of osteoarthritis of left knee, pain, confusion, safety awareness, cognition, medication management, impulsive behavior, wandering, and agitation. R65 is alert and oriented with intermittent confusion per normal and independent in facility but requires redirection from staff at times.R65's progress note, dated 2/18/26 at 5:52 AM entered by V33/RN, documents Behavior Note: (V33) was in another resident's room on 200 Hall and heard R65 yelling. Upon investigation, R65 was noted in the laundry room yelling at a laundry staff member. The laundry staff member attempted several times to get the resident to leave the laundry room as it is a staff only room and was unable to until V33 approached R65.R65's progress note, dated 2/28/26 at 1:58 AM entered by V32/LPN, documents R65 Resident receives daily skilled nursing services for OA (osteoarthritis) of left knee, pain, confusion, safety awareness, and cognition. R65 is alert and oriented with forgetfulness, wanders throughout the facility needing reminders at times to slow his gait and has poor safety awareness.R65's progress note, dated 3/23/26 at 6:24 PM entered by V31/LPN, documents R65 is alert with confusion per his baseline. R65 is independent in facility but does have occasional lapses in his safety awareness. R65 wanders at times and requires redirection. He gets restless when he is unable to leave the facility. He required redirection several times tonight regarding walking out the front doors without supervision.R65's elopement risk assessments, dated 3/24/26, document R65 scored a 3.0, indicating R65 was not at risk for elopement, and no care plan or interventions were required.On 4/23/26, R65's current care plan, dated 3/26/26, did not have any documentation of a comprehensive care plan addressing R65's risk for elopement, nor any elopement prevention interventions for R65's exit-seeking behaviors.On 4/23/26 at 9:30 AM, V13/Social Services Director stated the elopement risk assessments she completed for R65 on 6/27/25, 10/1/25, 12/30/25, and 3/24/26 do not accurately reflect R65's exit-seeking behaviors and elopement risk at the time of the assessments. V13 also stated the assessments should have documented R65 exhibited exit-seeking behaviors and had a history of purposeful exit seeking since R65 wanders and has exited the building several times. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Specific exit-seeking behaviors were not included in the assessment because the questions were marked incorrectly. Since R65 was not identified as being high risk for elopement, no care plan or interventions were developed related to R65's elopement risk and they should have been at the time of the assessment(s). V13 stated R65 made it out to the gazebo once and likes to go outside and look around, especially when it is nice outside. R65 had an electronic wandering device in place before, but he kept cutting it off; the device was replaced several times and then it was never put back on him. R65's wandering and exit-seeking behaviors were concerning initially when he got here because we didn't know him and he had those behaviors, but they are not concerning now because he is in a routine and staff all know him.R65's progress note, dated 3/29/26 at 6:45 PM entered by V30/LPN, documents R65 is alert and oriented with confusion. R65 came out of his room earlier this shift in a hurry and V30 asked him what the hurry was and where he was going, he then started smiling, turning around, and stated he was going outside. V30 reminded him he couldn't go outside without staff. R65 then went towards the front door and opened it.R65's progress note, dated 4/1/26 at 9:43 PM entered by V14/LPN, documents R65 has confusion, ambulates at a fast pace, has poor safety awareness, and likes to wander.R65's progress note, dated 4/7/26 at 11:14 AM entered by V16/Registered Nurse (RN), documents R65 required redirection due to lapses in safety awareness and had been wandering outside intermittently. The note also stated staff had to retrieve R65 from outside and re-educate him that he cannot go outside without assistance.On 4/23/26 at 11:56 AM, V16/RN stated R65 does not sleep well at night, especially between 2:00 AM and 3:00 AM. He wanders down 300 Hall, into a family member's room, and will go to the front door a lot. He often goes out the front door at shift change when the doors are unlocked. He likes to wander and he appears fine, but if you ask him certain questions, he has no idea. One day this winter around February, it was cold and snowing and he got outside around 4:00 AM because the front door was unlocked. He had no idea what he was doing and did not recognize that it was cold and snowing. V16 was unable to recall if the incident was documented or not.R65's current electronic health record and facility incident reports for R65 revealed no documentation of the incident in February 2026 as mentioned by V16.R65's progress note, dated 4/11/26 at 7:51 PM entered by V14/Licensed Practical Nurse (LPN), documents R65 had poor safety awareness, liked to wander, and went outside by himself.R65's progress note, dated 4/16/26 at 8:26 PM entered by V14/LPN, documents R65 went out of the facility by himself at 4:30 PM.R65's progress note, dated 4/22/26 at 8:36 PM entered by V14/LPN, documents R65 went outside the front door at 5:10 PM.On 4/23/26 at 11:47 AM, V14/LPN stated R65 was found outside the front door last night (4/22/26) at 5:10 PM by another staff member. V14 observed R65 in the dining room shortly before 5:00 PM and about 10 minutes later another staff member left the building and found R65 outside; he is quick, and he likes to roam. Staff inside were then notified of R65 being outside unsupervised by the staff member who found him. R65 has been getting out the front door more since the weather warmed up. About a year ago, before R65 was being monitored and was not allowed to go outside alone due to elopement behaviors, R65 wandered out the front door and was then observed by V16 from another resident's room window on 300 Hall alone and walking behind the back of the building. R65 was off the sidewalk and in a non-fenced area when observed. Staff were not aware of R65 being outside. It was probably about 10 minutes or so before I saw him last in the building and I'm not sure if I documented it, but V2/Director of Nursing was notified of the incident. If we didn't know R65 and he was new, these behaviors would be concerning to me and I would worry about his safety, but we all know him now. I was more concerned when he first admitted to the facility when he was wandering around outside around the building more and off the sidewalk.R65's current electronic health record and facility incident reports revealed no documentation of the incident described by V14 over a year ago.On 4/23/26 at 9:25 AM, V27/CNA stated R65 is confused and is known to wander throughout the building at all times of the day. R65 has got out of the building several times, goes to the doors several times each shift at the end of the hallways, and is hard to find most of the time because he walks so fast. R65 will be in one location for one minute and then you turn your head, and he is in a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	completely different location the next minute.On 4/23/26 at 9:50 AM, V28/RN stated R65 is confused and has very poor safety awareness. He requires a lot of redirection and verbal cueing from staff related to wandering and unsafe ambulation. R65 gets out the front door and does more when it is nice outside.On 4/23/26 at 10:00 AM, V2/Director of Nursing stated R65's Elopement Risk Assessments are inaccurate, and he is at high risk for elopement. V13/Social Services Director should have developed a care plan with interventions to address R65's elopement risk. V2 stated she thought R65 had a care plan and interventions in place because if he doesn't, he should. Fifteen-minute checks should be conducted to continuously monitor R65, although unable to determine if 15-minute checks were completed because they are not documented. We used to document them, but it has been going on for so long, we don't document them anymore.R65's current electronic health record has no documentation of 15-minute checks being completed for R65.On 4/23/26 at 10:05 AM, V1/Administrator and V2/Director of Nursing stated the alarm/security system worn by residents at risk for elopement had to be replaced four to five months ago because the tags (electronic wandering devices) couldn't be replaced. The facility just doesn't use the system because no one had been identified as being at risk for elopement in a long time.On 4/23/26 at 10:30 AM, V11/Staff Educator stated neither she nor Administration knew how to program the electronic wander devices because the devices haven't been used since they were purchased. V11 stated no residents were currently identified as being at risk for elopement.On 4/24/26 at 11:59 AM, V1/Administrator and V2/Director of Nursing confirmed R65 was not correctly assessed and identified as being at risk for elopement and a care plan and interventions should have been in place to prevent R65 from exiting the building unsupervised on multiple occasions. V1 stated the facility accepts residents with similar diagnoses and behaviors to the facility and this is a problem that needs fixed.The Immediate Jeopardy that began on 11/12/25 was removed on 4/28/26 when the facility took the following actions to remove the immediacy:On 4/24/26, R65 was reassessed for risk of elopement and was assess as at risk. One-on-one supervision was started for R65 until transfer to a memory care unit.On 4/24/26, R65 was discharged from the facility to a memory care unit.Starting on, and completed on, 4/24/26, the facility began reassessing all current residents for risk of elopement.Resident identified as at risk for elopement were immediately placed on hourly checks and an elopement door alarm bracelet was placed. Any residents refusing to wear an elopement door alarm bracelet will be placed on one-on-one supervision.Resident identified as at risk for elopement will have their picture and demographics placed in a binder and will be available at each nurse's station and reception.Starting on 4/24/26, all staff were in-serviced on the following by V2/Director of Nursing:Review of facility's elopement policyResidents identified as at risk for elopement will have their picture and demographics placed in a binder at each nurse's station and reception Identification of elopement risk behaviors Required monitoring and supervision for residents at risk for elopementA post-test was given to all staff to evaluate their understanding following the in-service.On 4/24/26, the facility implemented a standardized elopement risk assessment that will be completed for each resident upon admission, quarterly, annually, and with any change in conditionOn 4/24/26, monitoring systems and environmental safety measures were evaluated and implementedExit doors and alarm systems were checked for functionalityElopement door alarm bracelets for residents determined to be at risk of elopement will be checked for placement and functioning every shiftV2/Director of Nursing or designee will conduct QA (Quality Assurance) studies randomly twice weekly to ensure: residents are appropriately assessed for elopement risk, at risk residents have appropriate interventions and monitoring in place, and staff knowledge related to elopement risk and prevention.QA study findings will be reviewed at monthly QA/QAPI (Quality Assurance and Performance Improvement) meetings for three months to ensure compliance, and as needed thereafterAn emergency QA/QAPI was conducted on 4/24/26 to address elopement risk as a systemic issue and to implement ongoing monitoring and performance improvement measures

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to place use by dates on perishable foods. This failure has the potential to affect all 83 residents who reside in the facility. Findings include:The facility policy Storage of Dry Goods/Foods, undated, documents not in its entirety, Non-refrigerated foods, disposable dishware and other dry goods are stored in a clean, dry area which is free from contaminants.Opened products are labeled, dated with the use by date and tightly covered to protect against contamination including from insects and rodents. The facility policy Storage of Food and Supplies, undated, documents not in its entirety, Prepared foods stored in the refrigerator until service will be covered, labeled, and dated with Use by date or expiration date.All foods will be covered, labeled, and dated. The facility policy Storage of Frozen foods, undated, documents, If taken out of original container, food is tightly wrapped and labelled with the name of the item and the use by date. On 4/21/26 at 9:18 AM, initial tour of kitchen with the following observations: Seven types of cereal noted in clear airtight containers; top load freezer with two frozen bags of breaded chicken strips, one frozen bag of breaded chicken patties, and one bag of frozen hamburger patties; and sixteen condiment bottles in standup refrigerator all with no use by dates present; and two trays of individual servings of frozen nutritional supplements in standup freezer with no use by dates present on all servings except five. On 4/21/26 at 9:18 AM, a clear airtight container with a white granular substance under counter in kitchen noted with a use by date of 4/14/26 on the lid. V18 (Day Cook) stated the product in the container was grits and the date is the day she poured the grits into the container not the use by date. V18 and V3 (Dietary Manager) were asked about expiration dates and agreed it looks as if the grits were expired when looking at the sticker. V18 and V3 verified that the actual use by date should be on the sticker to tell when food is no longer to be served. On 4/21/26 at 2:17 PM, V1 (Administrator) stated that foods should have a received date and open date on them but unsure without looking at the facility policy about expiration/used by dates. V1 also stated, It would depend on the food in question because there is a little lead way, milk would be different than cereal which could go a little longer.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to perform Antibiotic Stewardship duties and fully utilize the Facility adopted McGeer's criteria for antibiotic use and education. This failure has the potential to affect all 83 residents that currently reside in the facility.Findings Include: The Facility's Antibiotic Stewardship Program policy dated 4/29/2025 documents The purpose of antimicrobial stewardship is to promote the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration, and route of administration to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance.The Facility's Antibiotic Stewardship Program policy dated 4/29/2025 documents Education: The facility will provide resources to clinician, nursing staff, residents, and families about resistance and appropriate antibiotic use. The facility will utilize McGeer's criteria when considering initiation of antibiotics. The facility will work with the hospital and the attending physician's order for a course of antibiotics to validate criteria used for initiation of antibiotics, including culture and hospital criteria used.The Facility's Infection Control Log dated February 2026 documents R9 received an ophthalmic antibiotic to left eye from 2/11/2026 through 2/18/2026. The facility could not provide any documentation of a McGeer's criteria used prior to initiation of antibiotic.The Facility's Infection Control Log dated February 2026 documents R12 received an oral antibiotic from 2/12/2026 through 2/16/2026 for Upper Respiratory Infection. The facility could not provide any documentation of a McGeer's criteria used prior to initiation of antibiotic.The Facility's Infection Control Log dated February 2026 documents R14 received an oral antibiotic from 2/13/2026 through 2/17/2026 for COPD (Chronic Obstructive Pulmonary Disease) exacerbation. R14's McGeer's criteria was incomplete and was dated 2/20/26, 3 days after completion of R14's antibiotic therapy.The Facility's Infection Control Log dated February 2026 documents that R15 received an oral antibiotic for a Urinary Tract Infection from 2/10/2026 through 2/14/2026. R15's McGeer's criteria dated 2/10/2026 was incomplete.The Facility's Infection Control Log dated February 2026 documents that R26 received an oral antibiotic from 2/10/2026 through 2/14/2026. R26's McGeer's criteria dated 2/10/2026 was incomplete.The Facility's Infection Control Log dated February 2026 documents that R70 received an oral antibiotic for an Upper Respiratory Infection from 2/2/2026 through 2/6/2026. R70's McGeer's criteria was incomplete and dated 2/20/2026, 18 days after R70's antibiotic therapy was complete.The Facility's Infection Control Log dated February 2026 documents that R33 received an oral antibiotic for a Urinary Tract Infection from 2/20/2026 through 2/24/2026. The facility could not provide any documentation of McGeer's criteria being used prior to initiation of the antibiotic.The Facility's Infection Control Log dated February 2026 documents that R42 received an oral antibiotic for Cellulitis from 2/19/2026 through 2/24/2026. The facility could not provide any documentation of McGeer's criteria being used prior to initiation of the antibiotic.The Facility's Infection Control Log dated February 2026 documents that R56 received an oral antibiotic for Cellulitis from 2/16/2026 through 2/26/2026. R56's McGeer's criteria dated 2/16/2026 was incomplete.The Facility's Infection Control Log dated February 2026 documents that R57 received an oral antibiotic from 2/20/2026 through 2/24/2026. R57's McGeer's criteria was incomplete and dated 2/24/2026, the last day of R57's antibiotic therapy.The Facility's Infection Control Log dated February 2026 documents that R64 received antibiotic ear drops for Eustachian dysfunction from 2/19/2026 through 2/24/2026. R64's McGeer's criteria was incomplete and dated 2/24/2026, the last day of R64's antibiotic therapy.The Facility's Infection Control Log dated February 2026 documents that R19 received an oral antibiotics from 2/22/2026 through 3/3/2026. R19's McGeer's criteria was incomplete and dated 2/24/2026, 2 days after R19 had already started her antibiotic.The Facility's Infection Control Log dated March 2026 documents that R88 received an oral antibiotic for Upper respiratory Infection from 3/6/2026 through 3/10/2026. R88's McGeer's criteria dated 3/6/2026 was incomplete.The Facility's Infection Control Log dated March 2026 documents that R82 received an oral antibiotic from3/5/2026 through (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/9/2026 for an Upper Respiratory Infection. R82's McGeer's criteria dated 3/6/2026 was incomplete.The Facility's Infection Control Log dated March 2026 documents that R16 received an oral antibiotic for a Urinary Tract Infection on 3/7/2026. R16's McGeer's criteria was incomplete and dated 3/13/2026, 6 days after R16 completed antibiotic therapy.The Facility's Infection Control Log dated March 2026 documents R27 received an oral antibiotic for Pneumonia from 3/11/2026 through 3/14/2026. R27's McGeer's criteria was incomplete and dated 3/13/2026, 2 days after R27 had already started antibiotic therapy.The Facility's Infection Control Log dated March 2026 documents R88 received an oral antibiotic from 3/7/2026 through 3/10/2026 for a Urinary Tract Infection. R88's McGeer's criteria was incomplete and dated 3/13/2026, 3 days after R88's antibiotic therapy was complete.The Facility's Infection Control Log dated March 2026 documents R5 received an oral antibiotic for a Wound Infection from 3/10/2026 through 3/24/2026. R5's McGeer's criteria was incomplete and dated 3/13/2026, 3 days after R5 began antibiotic therapy.The Facility's Infection Control Log dated March 2026 documents that R32 received an oral antibiotic for a Urinary Tract Infection from 3/17/2026 through 3/26/2026. R32's McGeer's criteria dated 3/17/2026 was incomplete.The Facility's Infection Control Log dated March 2026 documents that R33 received an oral antibiotic for a Urinary Tract Infection from 3/16/2026 through 3/26/2026. R33's McGeer's criteria was incomplete and dated 3/17/2026, 1day after R33 began antibiotic therapy.The Facility's Infection Control Log dated March 2026 documents that R51 received an oral antibiotic for an Upper Respiratory Infection from 3/20/2026 through 3/24/2026. R51's McGeer's criteria dated 3/2026 was incomplete.The Facility's Infection Control Log dated March 2026 documents that R76 received an oral antibiotic for Cellulitis from 3/22/2026 through 3/26/2026. R76's McGeer's criteria was incomplete and dated 3/27/2026, 1 day after R76 completed antibiotic therapy.The Facility's Infection Control Log dated March 2026 documents that R82 received an oral antibiotic for a Urinary Tract Infection from 3/21/2026 through 3/26/2026. R82's McGeer's criteria was incomplete and dated 3/27/2026, 1 day after R82 completed antibiotic therapy.The Facility's Infection Control Log dated March 2026 documents that R10 received an oral antibiotic for Boil from 3/24/2026 through 4/3/2026. R10's McGeer's criteria was incomplete and dated 4/17/2026, 14 days after completion of antibiotic therapy.The Facility's Infection Control Log dated March 2026 documents that R18 received an oral antibiotic from 3/25/2026 through 4/7/2026 for Cellulitis. R18's McGeer's criteria was incomplete and dated 3/27/2026, 1 day after R18 started antibiotic therapy.The Facility's Infection Control Log dated March 2026 documents that R67 received an oral antibiotic from 3/24/2026 through 3/30/2026 for a Urinary Tract Infection. R67's McGeer's criteria was incomplete and dated 3/27/2026, 3 days after R67 began antibiotic therapy.The Facility's Infection Control Log dated March 2026 documents that R50 received an oral antibiotic from 3/30/2026 through 4/6/2026 for an Upper Respiratory Infection. R50's McGeer's criteria was incomplete and dated 3/31/2026, 1 day after R50 began antibiotic therapy.On 4/23/2026 at 1:30 PM V26 (Registered Nurse/Infection Preventionist) confirmed facility used McGeer's criteria to determine the need for an antibiotic prior to the initiation of an antibiotic. V26 confirmed that the McGeer's criteria provided were not complete. V26 stated I have never seen this form before. When asked how it is determined whether or not a resident met McGeer's criteria V26 stated The computer does it.The Facility's Infection Control Log dated both February and March 2026 lists the following residents as Chronic: R14, R16, R18, R32, R35, R48, R50, R59, R61 and R71.On 4/23/2026 at 1:30 PM V26 (RN/IP) confirmed that there were ten residents (R14, R16, R18, R32, R35, R48, R50, R59, R61 and R71) on prophylactic antibiotic therapy. V26 could not provide any documentation of education of providers related to antibiotic stewardship guidelines that discourage the use of prophylactic antibiotic therapy.The Facility's Room Roster dated 4/21/2026 documents 83 residents currently reside in the facility.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop, implement and maintain an effective training program for all staff and determine the amount of time and the types of training necessary to meet the residents' needs. This failure has the potential to affect all 83 residents residing in the facility.Findings include: The Facility Resident Census Roster and Facility Matrix/802, dated 4/21/26, were reviewed. The Census Roster documents 83 residents reside in the facility.The Facility assessment dated [DATE] documents Staff Training and Competency- The facility in-service training calendar indicates the mandated annual training requirements as well as specific topics pertinent to provision of care and services to the identified population. The Assessment does not include the amount of time and the types of training necessary to meet the resident's needs.On 4/24/26 at 2:00 PM, V1 (Administrator) stated that during the monthly staff meetings they provide in-service education and training. V1 stated the monthly staff education tracking sheet has topics listed which were educated on and indicates the employees who attended the training if marked with an X next to the staff member's name. Review of the sheets show no documentation as to the subject matter covered. V1 stated he did not have an agenda that he followed for each of the monthly meetings' in-services. Stated he provided the in-services according to a schedule he has to follow that tells what topics to cover each month and did the in-services from memory because he has given the in-services for so long. V1 also stated that the facility did not have documentation of what educational material was presented at the monthly staff meeting nor could he ensure each staff member received the training.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all staff received mandatory training and education related to effective communication. This failure has the potential to affect all 83 residents residing within the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 4/21/26, were reviewed. The Census Roster documents 83 residents reside in the facility.The Facility assessment dated [DATE] documents Staff Training and Competency- The facility in-service training calendar indicates the mandated annual training requirements as well as specific topics pertinent to provision of care and services to the identified population. The Assessment does not include the amount of time and the types of training necessary to meet the effective communication training requirement.On 4/24/26 at 2:00 PM, V1 (Administrator) stated that during the monthly staff meetings they provide in-service education and training. V1 stated the monthly staff education tracking sheet has topics listed which were educated on and indicates the employees who attended the training if marked with an X next to the staff member's name. Review of the sheets show no documentation as to the subject matter covered. V1 stated he did not have an agenda that he followed for each of the monthly meetings' in-services. Stated he provided the in-services according to a schedule he has to follow that tells what topics to cover each month and did the in-services from memory because he has given the in-services for so long. V1 also stated that the facility did not have documentation of what educational material was presented at the monthly staff meeting nor could he ensure each staff member received the training.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all staff received mandatory training and education related to rights of the residents and responsibilities of the facility to care for its residents. This failure has the potential to affect all 83 residents residing within the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 4/21/26, were reviewed. The Census Roster documents 83 residents reside in the facility.The Facility assessment dated [DATE] documents Staff Training and Competency- The facility in-service training calendar indicates the mandated annual training requirements as well as specific topics pertinent to provision of care and services to the identified population. The Assessment does not include the amount of time and the types of training necessary to meet the rights of the residents and responsibilities of the facility to care for its residents training requirement.On 4/24/26 at 2:00 PM, V1 (Administrator) stated that during the monthly staff meetings they provide in-service education and training. V1 stated the monthly staff education tracking sheet has topics listed which were educated on and indicates the employees who attended the training if marked with an X next to the staff member's name. Review of the sheets show no documentation as to the subject matter covered. V1 stated he did not have an agenda that he followed for each of the monthly meetings' in-services. Stated he provided the in-services according to a schedule he has to follow that tells what topics to cover each month and did the in-services from memory because he has given the in-services for so long. V1 also stated that the facility did not have documentation of what educational material was presented at the monthly staff meeting nor could he ensure each staff member received the training.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all staff received mandatory training and education on abuse, neglect and exploitation including activities which constitute abuse, neglect and exploitation, procedures for reporting incidents, dementia management and abuse prevention. This failure has the potential to affect all 83 residents residing within the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 4/21/26, were reviewed. The Census Roster documents 83 residents reside in the facility.The Facility assessment dated [DATE] documents Staff Training and Competency- The facility in-service training calendar indicates the mandated annual training requirements as well as specific topics pertinent to provision of care and services to the identified population. The Assessment does not include the in-service/competency training to meet the abuse, neglect and exploitation including activities which constitute abuse, neglect and exploitation, procedures for reporting incidents, dementia management and abuse prevention requirement.On 4/24/26 at 2:00 PM, V1 (Administrator) stated that during the monthly staff meetings they provide in-service education and training. V1 stated the monthly staff education tracking sheet has topics listed which were educated on and indicates the employees who attended the training if marked with an X next to the staff member's name. Review of the sheets show no documentation as to the subject matter covered. V1 stated he did not have an agenda that he followed for each of the monthly meetings' in-services. Stated he provided the in-services according to a schedule he has to follow that tells what topics to cover each month and did the in-services from memory because he has given the in-services for so long. V1 also stated that the facility did not have documentation of what educational material was presented at the monthly staff meeting nor could he ensure each staff member received the training.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all staff received mandatory training and education on the elements and goals of its Quality Assurance Performance Improvement program. This failure has the potential to affect all 83 residents residing within the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 4/21/26, were reviewed. The Census Roster documents 83 residents reside in the facility.The Facility assessment dated [DATE] documents Staff Training and Competency- The facility in-service training calendar indicates the mandated annual training requirements as well as specific topics pertinent to provision of care and services to the identified population. The Assessment does not include specific in-service/competency training to meet the elements and goals of its Quality Assurance Performance Improvement program training requirements.On 4/24/26 at 2:00 PM, V1 (Administrator) stated that during the monthly staff meetings they provide in-service education and training. V1 stated the monthly staff education tracking sheet has topics listed which were educated on and indicates the employees who attended the training if marked with an X next to the staff member's name. Review of the sheets show no documentation as to the subject matter covered. V1 stated he did not have an agenda that he followed for each of the monthly meetings' in-services. Stated he provided the in-services according to a schedule he has to follow that tells what topics to cover each month and did the in-services from memory because he has given the in-services for so long. V1 also stated that the facility did not have documentation of what educational material was presented at the monthly staff meeting nor could he ensure each staff member received the training.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all staff received mandatory training and education for the Infection Prevention and Control program which includes the written standards, policies and procedures for the program. This failure has the potential to affect all 83 residents residing within the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 4/21/26, were reviewed. The Census Roster documents 83 residents reside in the facility.The Facility assessment dated [DATE] documents Staff Training and Competency- The facility in-service training calendar indicates the mandated annual training requirements as well as specific topics pertinent to provision of care and services to the identified population. The Assessment does not include specific in-service/competency training or topics to meet the Infection Prevention and Control program which includes the written standards, policies and procedures for the program requirements.On 4/24/26 at 2:00 PM, V1 (Administrator) stated that during the monthly staff meetings they provide in-service education and training. V1 stated the monthly staff education tracking sheet has topics listed which were educated on and indicates the employees who attended the training if marked with an X next to the staff member's name. Review of the sheets show no documentation as to the subject matter covered. V1 stated he did not have an agenda that he followed for each of the monthly meetings' in-services. Stated he provided the in-services according to a schedule he has to follow that tells what topics to cover each month and did the in-services from memory because he has given the in-services for so long. V1 also stated that the facility did not have documentation of what educational material was presented at the monthly staff meeting nor could he ensure each staff member received the training.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) were provided and completed a minimum of 12 hours of in-service training per year. This failure has the potential to affect all 83 residents residing in the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 4/21/26, were reviewed. The Census Roster documents 83 residents reside in the facility.The Facility assessment dated [DATE] documents Staff Training and Competency- The facility in-service training calendar indicates the mandated annual training requirements as well as specific topics pertinent to provision of care and services to the identified population. The Assessment does not include specific in-service/competency training and topics or how the Certified Nurse Aides required 12-hours of training will be conducted.The 2025 Certified Nurse Aide In-service Tracking Sheet with the name of the topics covered monthly documents 42 Certified Nurse Aides did not meet the 12-hour training requirement.On 4/24/26 at 3:45 PM, V11 (Staff Educator) confirmed the CNAs working at the facility should receive 12 hours of continuing education yearly at minimum. V11stated the 2025 Certified Nurse Aide Tracking Sheet documented 42 CNAs had not completed the 12 hours of the minimum yearly training.On 4/24/26 at 2:00 PM, V1 (Administrator) stated the monthly staff education tracking sheet indicates the employee attended the training if marked with an X. The attendance of the training per month indicates one hour of education was completed. V1 reviewed the 2025 Certified Nurse Aide Tracking Sheet and agreed 42 Certified Nurse Aides had not completed the 12 hours of minimum yearly training and should have.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all staff received mandatory training and education related to Behavioral Health. This failure has the potential to affect all 83 residents residing within the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 4/21/26, were reviewed. The Census Roster documents 83 residents reside in the facility.The Facility assessment dated [DATE] documents Staff Training and Competency- The facility in-service training calendar indicates the mandated annual training requirements as well as specific topics pertinent to provision of care and services to the identified population. The Assessment does not include specific in-service/competency training or topics to meet the Behavioral Health training requirements.On 4/24/26 at 2:00 PM, V1 (Administrator) stated that during the monthly staff meetings they provide in-service education and training. V1 stated the monthly staff education tracking sheet has topics listed which were educated on and indicates the employees who attended the training if marked with an X next to the staff member's name. Review of the sheets show no documentation as to the subject matter covered. V1 stated he did not have an agenda that he followed for each of the monthly meetings' in-services. Stated he provided the in-services according to a schedule he has to follow that tells what topics to cover each month and did the in-services from memory because he has given the in-services for so long. V1 also stated that the facility did not have documentation of what educational material was presented at the monthly staff meeting nor could he ensure each staff member received the training.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to safely store medications for two (R28, R71) of nineteen residents reviewed for medication administration. The facility also failed to assure a medication cart was locked when not attended, this failure has the potential to affect all 31 (R1, R5, R7, R9, R11, R12, R14, R23, R24, R26, R28, R31, R34, R35, R36, R41, R44, R48, R51, R52, R54, R58, R63, R64, R66, R69, R71, R80, R81, R83, R85) residents that reside on the 200 hall. Findings include:The facility policy, Storage of Medications, dated 10/25/2014, documents not in its entirety, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications. Medication rooms, carts, emergency kits/boxes, and medication supplies are locked when not attended by persons with authorized access.The facility policy, Bedside Medication Storage, dated 10/25/2014, documents not in its entirety, Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team.A written order for the bedside storage of medication is present in the resident's medical record.The facility policy, Medication Administration, dated 10/25/2014, documents not in its entirety, During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained at all times for all resident information (e.g., MAR/Medication Administration Record) [by closing the MAR book/covering the MAR sheet or computer screen] when not in use.R28's Resident Face Sheet documents R28's admission date to the facility was 10/13/25 and R28's diagnoses include but are not limited to Other Intervertebral disc degeneration, Thoracolumbar Region (Primary), Chronic Diastolic (Congestive) Heart Failure (Admission), Chronic Obstructive Pulmonary Disease Unspecified, and Unspecified Dementia Unspecified Severity without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, or Anxiety.R28's Physician orders, dated 10/13/2025, documents R28 has an order for Albuterol Sulfate (bronchodilator) solution for nebulization, 2.5mg (milligram)/3ml (milliliter) inhale 3ml four times a day at 5:00 AM, 11:00 PM, 4:00 PM, 8:00 PM. R28 does not have a current order to self-administer medications.On 4/21/2026 at 10:32 AM, R28 was observed sitting in recliner in his room with nebulizer machine noted on nightstand next to R28's left side and a plastic drinking cup with five, 3ml (milliliter) vials of Albuterol Sulfate 2.5mg (milligrams)/3ml placed in it. R28 stated that the nurses leave those there so if I need one all I have to do is call them and they grab one from that cup and fill my machine up for me.On 4/21/2026 at 10:55 AM V9 (Registered Nurse) verified that R28 had five, 3ml (milliliter) vials of 2.5mg (milligram)/3ml of Albuterol Sulfate in his room and stated that they should not have been left in room.On 4/21/2026 at 2:22 PM, V1 (Administrator) and V2 (Director of Nursing) stated that medications should not be left in a resident's room unless they have a physician order to self-administer.On 4/23/2026 at 9:25 AM, the 200 Hall medication cart was observed in hallway across from room [ROOM NUMBER]. Medication cart was unlocked and unattended with a medication cup noted on top of the cart with crushed medicine in pudding.On 4/23/2026 at 9:30 AM, V1 (Administrator) noted down the hall and was asked to come to the medication cart. V1 observed the medication cart was unlocked and unattended by nursing staff so V1 immediately locked the cart. V1 also verified that the medication cup with crushed (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medicine was on top of cart. V1 called V12 (Licensed Practical Nurse) to come into the hallway after she assisted with resident care. V1 told V12 that her cart was unattended and not locked with medication on top of the cart and verified that it should not be unlocked when unattended or have medication on top of the cart unattended. V12 stated she got pulled away unexpectedly. V12 stated that the medicine crushed in the cup on top of the cart belonged to R71 and contained Acetaminophen 500mg (milligram) 1 tablet, Calcium Carbonate with Vitamin D3 600mg-400unit 1 tablet, Mucinex Extended Release 600mg 1 tablet, Multivitamin 1 tablet, Furosemide 40mg 1 tablet, and Metoprolol Extended Release 100mg 1 tablet.R71's Resident Face Sheet documents R71's admitted to the facility on [DATE] and R71 diagnoses include but are not limited to Parkinsonism Unspecified (Primary), Primary Osteoarthritis Other Specified Site (Admission), Malignant Neoplasm of Colon, Essential Hypertension, and Supraventricular Tachycardia Unspecified.R71 has the following Physician Orders for Acetaminophen 500mg (milligram) 1 tablet twice daily, Calcium Carbonate with Vitamin D3 600mg-400unit 1 tablet daily, Mucinex Extended Release 600mg 1 tablet every 12 hours, Multivitamin 1 tablet daily, Furosemide 40mg 1 tablet daily, and Metoprolol Extended Release 100mg 1 tablet daily.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident care plans were updated and accurately reflected residents' current code status and advanced directive wishes consistent with signed Practitioner Order for Life-Sustaining Treatment (POLST) forms for two (R3 and R65) of 24 residents reviewed for advanced directives in the sample of 64.Findings include:The facility's Advanced Directive and Advanced Care Planning/POLST (Physician's Order for life Sustaining Treatment) Guideline, dated [DATE], includes: the objective of this guideline is to establish a facility practice to educate and inform the residents of their rights, promoting the residents their rights to accept or refuse medical or surgical treatment and to formulate an advanced directive in assisting the resident to exercise his/her rights. Changes to the resident choices for advanced directives will be documented, included in the resident plan of care, specific documents will be updated as necessary, physician orders will be obtained to reflect new choices, and all items will be communicated to staff providing resident care. The interdisciplinary team will identify, clarify, and review, as part of the comprehensive care planning process, the existing care instructions along with resident's goals and wishes as the resident's medical condition changes.1. R3's POLST form, signed and dated on [DATE] by V29/Medical Director, documents, No CPR (Cardio-pulmonary resuscitation): Do Not Attempt CPR (DNAR/Do Not Attempt Resuscitation). Comfort-Focused Treatment: Primary Goal is maximizing comfort through symptom management.R3's care plan, dated [DATE] to [DATE], documents, I do not want to die. I have a POLST form signed FULL CODE.On [DATE] at 11:30 AM, V13/Social Services Director (SSD) stated V13 is responsible for updating the care plans to reflect each resident's current code status and confirmed R3's care plan and POLST forms did not match and should have. V13 stated there was a recent change, about two weeks, in R3's code status due to a change in condition requiring hospice services and the care plan was not updated at the time of the change to reflect the R3's current code status.2. R65's POLST form, signed and dated on [DATE] by V29/Medical Director, documents, No CPR: Do Not Attempt CPR. Selective-Treatment: Primary goal is treating medical conditions with limited medical measures.R65's care plan, dated [DATE], documents, I do not want to die. I am a FULL CODE. [DATE] DNR. Be aware I am a FULL CODE.On [DATE] at 11:33 AM, V13/SSD stated the care plan should not document that R65 is a full code because R65's POLST form documents do not attempt CPR. The care plan should only document R65 is a DNR (Do Not Resuscitate).On [DATE] at 11:35 AM, V20/Care Plan Coordinator stated code statuses should be included in the care plan and the signed POLST form is scanned into the chart. All residents' code statuses included in the care plan should match their signed POLST forms.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure psychotropic medications had proper indications for use and failed to use nonpharmacologic interventions other than psychotropic medication for three residents (R1, R2, R56) of five residents reviewed for unnecessary medications in a total sample of 64.Findings Include: The Facility's undated Psychotropic Medications policy documents This facility shall ensure that residents do not receive psychotropic drugs unless such therapy is necessary to treat a specific condition is diagnosed by the attending physician or psychiatric consult. Chemical Restraints shall not be used to discipline a resident or for staff convenience, but only in accordance with the physician's orders when other interventions have proven unsuccessful, as documented in the medical record. The Facility's undated Psychotropic Medications policy documents The following specific conditions are acceptable to warrant the use of antipsychotic medications and one of these should be documented in the medical record to support the use of the drug: a. Schizophrenia b. Schizoaffective Disorder c. Delusional Disorder d. Psychotic Mood Disorders (including mania and depression with psychotic features) e. Acute Psychotic Episodes f. Brief Reactive Psychosis g. Schizophrenic Disorder h. Atypical Psychosis i. Tourette's Disorder j. Huntington's Disease k. Short term (seven days) symptomatic treatment of hiccups, nausea, vomiting and/or pruritus' l. As an adjunct to analgesic therapy for acute intractable pain e.g. terminal cancer m. Alzheimer's Disease including dementia with associated psychotic and/or agitated features as defined by: 1) Specific behaviors as quantitatively (number of episodes) and objectively (e.g. biting, scratching and kicking) documented by facility personnel which caused the residents to represent a danger to themselves, or represent a danger to others including staff, or actually interferes with staff's ability to provide care 2) Psychotic symptoms not exhibited as specific behaviors listed above. n. continuous crying out, screaming, yelling or pacing if these specific behaviors cause an impairment in functional capacity. The Facility's undated Psychotropic Medications policy documents 9. Antipsychotic drugs should not be used if one or more of the following is/are the only indication: a. Simple pacing b. Wandering c. Poor self-care d. Restlessness e. Periodic crying out, yelling or screaming f. Impaired Memory g Unspecified agitation h. Depression i. Insomnia j. Being unsociable k. Indifference to surroundings l. Fidgeting m. Nervousness n. Being uncooperative o. Anxiety. If an antipsychotic drug is being used in the absence of a diagnosis or specific behavior as listed above (Alzheimer's Disease. And/or Item IX) then a licensed nurse or licensed pharmacist will request the attending physician to review the medication plan consider a gradual dose reduction. The 2026 IC-10-CM Diagnosis Book documents Neurocognitive disorder due to known physiological condition diagnosis should not be used for reimbursement purposes as there are many other more detailed diagnosis available. The 2026 IC-10-CM Diagnosis Book documents that Neurocognitive disorder due to known physiological condition: Clinical Information: A prodromal phase of cognitive decline that may precede the emergence of Alzheimer disease and other dementias. It may include impairment of cognition, such as impairments in language, visuospatial awareness, attention and memory. 1.R1's Medical Record documents she was admitted on [DATE] with diagnoses to include but not (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited to Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance with anxiety, Generalized Anxiety disorder, Major depressive disorder, recurrent, unspecified and Mild Neurocognitive disorder due to known physiological condition with behavioral disturbance. R1's current Physician Order Sheet dated April 2026 documents R1 takes Clonazepam 0.5 mg (milligram) twice a day for Anxiety, Hydroxyzine (a medication used to treat anxiety, tension and as a sedative before or after surgery) for Anxiety, Fluoxetine (Antidepressant) 10 mg every night for depression, Loxapine succinate 5mg every day(Antipsychotic) for Neurocognitive disorder due to known physiological condition with behavioral disturbance, and Memantine 15 mg every day (used to improve memory, awareness, and function ability in patients with moderate-to-severe Alzheimer's Dementia). R1's Behavior Monitoring Audit for January 2026 documents that R1 had behavior of yelling out/anxious on 1/7/26, 1/14/26, 1/22/26 and 1/29/26. R1's Behavior Monitoring Audit for February 2026 documents that R1 had behavior of yelling out/anxious on 2/5/26, 2/12/26, 2/19/26 and 2/28/26. R1's POC (Point of Care Documentation) for February 2026 documents R2 had Repetitive Verbalizations and Persistent Anger with Self or others that was easily altered with non-pharmacologic intervention. On 4/23/26 V2 (Director of Nursing) confirmed that R1's care plan did not document any resident specific interventions for anxiety or dementia. On 4/21/26 R1 stated I am a nervous child that can need a lot of reassuring at times. I try to get out and go to activities as much as possible, I'm sure my anxiety is related to being lonesome sometimes. I know they (staff) get irritated when I get insistent on answers. R1 stated she knows she is on medications for my nervousness. Throughout the survey R1 attended activities and was pleasant with staff and other residents. 2. R2's Electronic Health Record documents R2 was admitted to the facility on [DATE] with diagnoses to include Mild Neurocognitive Disorder due to known physiological condition with behavioral disturbance, Diabetes, Hypertension, Alzheimer's Disease, Depression and Anxiety. R2's Physician's Order dated 6/2/25 documents Lorazepam 0.5 milligrams by mouth two times per day. R2's Physician's Order documents Lorazepam 0.5 milligrams by mouth as needed for anxiety for 14 days. This order has been renewed every 14 days since 4/14/25. R2's Medication Administration Record from 3/21/26-4/21/26 documents R2 received PRN (as needed) Lorazepam 0.5 milligrams six times. The indication for use on the dosages given on 4/16/26 and 4/17/26 was Pain. The other dosages given were documented as being given for Behavior Issues. R2's Physician's order dated 9/8/25 documents Risperdal 0.5 milligrams by mouth daily for Mild Neurocognitive Disorder due to known physiological condition with Behavioral Disturbance. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Minimum Data Set assessment dated [DATE] documents R2 does not have any behaviors. R2's Point of Care documentation for behaviors from 3/21/26-4/21/26 documents R2 had behaviors (tearful, anxious, sad, apathetic) three times in that time frame. R2's Nursing Progress Notes from 3/21/26-4/21/26 has one progress note addressing behaviors. R2's Nursing Progress Note dated 4/5/26 documents R2 noted to be confused and tearful this shift. Repeated reassurance provided. On 4/22/26 at 2:15 PM, V19 (CNA/Certified Nurse Aide) reported R2's only behavior is R2 worries and asks if family is home. V19 reported staff tell R2 her family is safe, and she is better. R2 is not a harm to herself or others. On 4/22/26 at 2:40 PM, V14 (LPN/Licensed Practical Nurse) reported R2 cries, asks for her family, is restless, and tries to get up. On 4/22/26 at 3:00 PM, V1 (Administrator) and V2 (Director of Nursing) reported R2 will have episodes of crying, R2 is inconsolable, and this is detrimental to R2. On 4/23/26 at 11:42 AM, V20 (LPN) reported R2 has been on the same psychotropic drug regimen for a year and that her behaviors are not harmful to R2 or other residents. V20 reported R2 is in activity programs throughout the day and likes to be around people. 3.R56's Medical Record documents that she was admitted to the facility on [DATE] with diagnosis to include but not limited to Vascular Dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, restlessness and agitation, Unspecified dementia, moderate, with psychotic disturbance, and Mild neurocognitive disorder due to known physiological condition with behavioral disturbance. R56's current Physician Order Sheet dated April 2026 documents that R56 receives Olanzapine (Antipsychotic) 10 mg daily six times a week, Olanzapine 5 mg on Sundays, Sertraline (Antidepressant) 150 mg daily six times a week, Sertraline 100 mg on Sundays. R56's Nurse's Notes do not document any behaviors from January 2026 to present. R56's POC (Plan of Care) documentation does not document any behaviors from January 2026 to present. On 4/22/26 R56 was pleasant, stated she knew she took medications (resident made a circling motion towards her temple). Throughout the survey R56 attended activities and interacted with other residents and staff pleasantly. On 4/23/26 V2 (Director of Nursing) stated that R56 has a history of hallucinations and being convinced she sees things others do not. V2 stated these hallucinations were not at all harmful to R56 or any other residents. (R56) gets aggravated because she thinks something is there, but it doesn't seem to ever be anything scary or harmful to (R56).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who depend on staff's assistance for Restorative Care services received care as ordered for four of four residents (R6, R8, R16, R18 R43) reviewed for Restorative Care, in a sample of 64. Findings include:The Restorative Nursing Policy, not dated, documents each resident will be assessed for restorative/rehabilitative needs and placed in nursing director programs. Each program is directed toward assisting residents to achieve and maintain optimal levels of self-care and independence, thus enhancing self-esteem, promoting active participation in daily living and improving quality of life. This ensures that each resident's individual rehabilitative needs are identified, and appropriate nursing measures are implemented to achieve a maximum level of independence. Restorative Nursing Programs include range of motion and walking. Restorative services and the resident's response toward goals will be documented as follows by staff implementing the plan on one or more of the following forms: Restorative Documentation Record, Nursing Progress Notes, ADL (Activities of Daily Living) Record and/or Treatment Administration Record. The Range of Motion Exercises (ROM) policy, not dated, documents ROM is conducted to exercises resident's joints and muscles. If ROM is passive, the resident's body part being exercised must be supported. 1. R6 was admitted on [DATE] with diagnoses of Polyneuropathy, Type 2 Diabetes Mellitus, Small Cell-B Cell Lymphoma, Chronic Lymphocytic Leukemia, Anemia, Atherosclerosis Heart Disease and Muscle Wasting. The Minimum Data Set (MDS) dated [DATE] documents R6 has moderate cognitive impairment. R6's Physician's Order dated 4/17/26 documents R6 will perform active range of motion, two sets of 15 repetitions three times daily and report pain, intolerance, and/or muscle spasm during active range of motion to the nurse. R6's current care plan's section ADLs (Activities of Daily Living) Functional Status/Rehabilitation Potential documents R6 requires active range of motion to bilateral lower extremities and will perform two sets of 15 repetitions of active range of motion to bilateral extremities with staff assistance and verbal cues. R6's ADL Functional Analysis dated 12/24/25 documents R6 requires supervision to touching assistance with mobility and partial to moderate assistance with self-cares. The ADL Functional assessment dated [DATE] documents R6 requires substantial to maximal assistance with mobility and dependent on staff for self-cares. R6's Nursing Rehabilitation Time Log report dated 4/17/26 to 4/22/26 documents active range of motion was conducted by Certified Nurse Aides two to three times daily. On 4/22/26 at 9:55 AM, R6 stated staff have not conducted range of motion exercises with him since admission and he has gotten weaker. On 4/23/26 at 2:00 PM, V24 (Certified Nurse Aide) stated Isn't toileting part of the restorative cares? (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V24 stated she was unaware that R6 needed active range of motion. 2. R8 was admitted on [DATE] with diagnoses of Rheumatoid Arthritis, Type 2 Diabetes Mellitus, Thrombosis Upper Extremity, Major Depressive Disorder and Intervertebral Disk Degeneration Lumbar Region. The Minimum Data Set (MDS) dated [DATE] documents R8 is cognitively intact. R8's Physician's Order dated 9/26/25 documents R8 will perform active range of motion, two sets of 15 repetitions three times daily and report pain, intolerance, and/or muscle spasm during active range of motion to the nurse. R8's current care plan's section ADLs (Activities of daily Living) Functional Status/Rehabilitation Potential documents R8 requires active range of motion to bilateral lower extremities and will perform two sets of 15 repetitions of active range of motion to bilateral extremities with staff assistance and verbal cues. R8's Nursing Rehabilitation Time Log report dated 4/9/26 to 4/22/26 documents active range of motion was conducted two to four times daily by Certified Nurse Aides. On 4/22/26 at 10:19 AM, R8 stated staff have not conducted range of motion exercises. 3. R16's Electronic Health Record documents R16 admitted to the facility on [DATE] with diagnoses to include Osteoarthritis, Atrial Fibrillation, Hypertension, Hyperlipidemia, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease. R16's Physician's Order dated 4/1/26 documents R16 will ambulate 100 feet three times per day. R16's Care Plan Problem dated 4/1/26 documents R16 requires restorative nursing walking program. This problem statement has a goal for R16 to ambulate 100 feet. R16's Brief Interview for Mental Status dated 2/10/26 documents a score of 13 which indicates no impairment to minimal cognitive impairment. On 4/21/26 at 9:15 AM, R16 stated I'm not getting the help I need. They said they would walk me every day and it doesn't happen. I want to be able to go home. On 4/22/26 12:36 PM, R16 stated They walked me today, they have walked me 1x this week. I want to get back home On 4/22/26 at 12:44 PM, V6 (CNA) reported V6 rarely walks R16. On 4/22/26 at 12:49 PM, V5 (CNA) stated V5 ambulates R16 to the bathroom if R16 is having a good day. V5 reported R16 is usually ambulated by V17 (CNA). On 4/22/26 at 1:00 PM, V17 (CNA) reported she ambulates R16 when she is here and V17 is scheduled to work Monday through Friday each week. V17 reported R16 has stated she wants to go home in June 2026. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/26 at 1:44 PM, V10 (CNA) reported V10 never ambulates R16. On 4/22/26 at 2:15 PM, V19 (CNA) reported R16 doesn't ask staff to walk her, but V19 would do it if R16 asked to be ambulated. On 4/23/26 at 10:04 AM, R67 (R16's roommate) who is cognitively intact reported R67 has seen staff ambulate R16, but not very often. 4. R18's EHR (Electronic Health Record) documents R18 admitted to the facility on [DATE] with diagnoses to include Fibromyalgia, Heart Failure, Atherosclerotic Heart Disease, Hypothyroidism, Osteoporosis, and Hypertension. R18's Physician's Order dated 5/14/25 documents R18 will perform active range of motion to bilateral upper extremities three times per day with staff. R18's Care Plan dated 5/19/25 documents R18 requires active range of motion to bilateral upper extremities. R18's Brief Interview for Mental Status dated 4/14/26 documents a score of 15 which indicates no cognitive impairment. On 4/22/26 at 1:45 PM R18 reported staff occasionally perform range of motion to his extremities. On 4/23/26 at 10:37 AM V22 (CNA) reported she does not perform range of motion on R18 however in the point of care documentation she performed range of motion on R18 six times in April 2026 for 15 minutes. 5. R43 was admitted on [DATE] with diagnoses of Osteoarthritis Right Knee, Type 2 Diabetes Mellitus, Atherosclerosis, Ventricular Tachycardia, Chronic Systolic Heart Failure, Ischemic Cardiomyopathy and Generalized Anxiety Disorder. The Minimum Data Set (MDS) dated [DATE] documents R43 is cognitively intact. R43's Physician's Order dated 3/31/26 documents R43 will receive two sets of 15 repetitions of Passive Range of Motion to bilateral lower extremities with staff assistance and verbal cues three times daily. R43's current care plan documents R43 requires passive range of motion to bilateral lower extremities and will receive two sets of 15 repetitions of passive range of motion to bilateral lower extremities. R43's Nursing Rehabilitation Time Log report dated 4/9/26 to 4/22/26 documents passive range of motion was conducted two to four times daily by Certified Nurse Aides. The log documented V7 (Certified Nurse Aide/CNA) conducted passive range of motion exercises on 4/22/26 at 10:17 AM. On 4/21/26 at 10:30 AM, R43 stated I'm not doing good. I'm not getting therapy so I'm not getting any stronger. It's very depressing. They never get me up and walk me and never have. R43 stated staff do not exercise him and they lift him with a mechanical lift to get out of bed. On 4/22/26 at 8:37 AM, V8 (R43's family member) stated R43 is having a hard time with the loss of (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical activity. Stated (R43) had a meltdown yesterday. Hospice won't pay for physical therapy. Psychologically, his well-being is at risk. I would like for him to do some basic exercises and standup sometimes. On 4/22/26 at 12:59 PM, upon request, V7 (Certified Nurse Aide/CNA) instructed R43 to conduct the following active range of motion exercises: one set of 10 bilateral leg extensions, one set of 10 bilateral lower leg marches, 1 set of 10 bilateral arm circles, 1 set of five resistive pushing and pulling of bilateral arms and 1 set of two chin to chest, tilt head right, tilt head left and tilt head backwards. V7 (Certified Nurse Aide/CNA) demonstrated the ADL's Functional Status/Rehabilitation Potential section of the care plan which was posted on the inside of R43's closet door and stated the posted care plan is how the CNA's know what care to conduct with the residents, and the care plan should be posted in each resident's room inside their closet door. V7 reviewed R43's posted care plan and agreed the care plan noted passive range of motion to be conducted, and bilateral upper extremity nor head exercises were on the care plan and should not have been conducted, nor were two sets of 15 repetitions. V7 stated she had not conducted range of motion exercises with R43 during her shift on 4/22/26. When asked why V7 documented in the electronic record that passive range of motion was conducted by V7 on 4/22/26 at 10:17 AM, V7 stated I thought dressing him was considered passive range of motion. On 4/22/26 at 1:05 PM during exercises with V7, R43 stated How come now you can exercise me? No one has exercised me since I've been here and that's all I've asked to do. I just want to get stronger and get myself to the bathroom. If someone would show me what to do, I would do them (exercises) ten times a day. R43 asked when staff would be back to do more exercises and stated That (exercising) was great. On 4/23/26 at 2:00 PM, V8 (R43's Family Member) and R43 stated neither of them were aware there was a physician's order and the care plan included that exercises were ordered to be conducted three times daily. On 4/23/26 at 2:15 PM, V17 (Restorative Nurse Aide) stated she conducts walking restorative cares, not range of motion exercises. On 4/23/26 at 1:20 PM, V17 (Restorative Certified Nurse Aide) stated she walks R8 when he lets her but agreed active/passive range of motion is not conducted on R4, R8 and R48. On 4/23/26 at 2:20 PM, V1 (Administrator) stated residents should be getting their active/passive range of motion exercises conducted as ordered and was unaware the exercises had not been conducted.

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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** Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene and changed gloves when providing urinary catheter care and maintained a urinary catheter bag off the floor for one (R32) of three residents reviewed for urinary catheters in the sample of 64 residents. Findings include:The facility's policy for Urinary Care, Catheter, dated January 2016, includes the purpose of the procedure is to prevent catheter-associated urinary tract infections. Following aseptic insertion of the catheter, maintain a closed drainage system. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered. Use Standard Precautions when handling or manipulating the drainage system. Use clean technique when handling or manipulating the catheter, tubing, or drainage bag. Be sure the catheter tubing and drainage bag are kept off the floor. The facility's Catheter Care - Foley Catheter Care procedure checklist, not dated, includes perform hand hygiene. Use infection control measures and standard precautions during the entire procedure. [NAME] gloves and use your non-dominant hand to expose the urethral meatus and hold this position throughout the procedure: For men, retract the foreskin (if needed) and hold the penis just below the head. Apply a cleansing agent to a wet washcloth. Grasp the catheter with two fingers near the meatus. Clean around the meatus using a clean area of the washcloth for each stroke or motion: use a circular motion for males. Apply a cleansing agent to a new, wet washcloth and clean at least four inches of the catheter - with one stroke, clean downward, away from the meatus and repeat as needed with a clean area of the washcloth. Rinse and dry the urethral meatus and catheter using the same cleansing procedure. R32's face sheet documents R32 was admitted on [DATE] and includes the following medical diagnoses: history of UTIs, cerebral palsy, diabetes, prostate cancer, neuromuscular dysfunction of the bladder, chronic kidney disease, and contracture.R32's MDS (Minimum Data Set) assessment, dated 2/3/26, shows R32 is cognitively intact.R32's physician order, dated 4/23/26, documents a start date of 5/22/25 for Cephalexin (antibiotic) 250 mg (milligrams) by mouth daily for recurrent UTIs. No end date is documented.R32's current care plan documents: Problem: R32 has a history of prostate cancer, neurogenic bladder, and requires a urinary catheter; Goal: R32 will be free of signs and symptoms of UTIs; Approaches: Change catheter as ordered and as needed, monitor me for blood in my urine, dark, foul-smelling urine, elevated temperature, and sediment - notify the doctor if signs present; provide me with catheter care each shift and as needed. The care plan does not include R32's long-term use of antibiotics or recurrent urinary tract infections.R32's progress note, dated 3/10/26, states R32 was complaining his penis hurt and stated he thought he had a UTI again. Urine is cloudy and pink-tinged currently. Urology was notified. Will continue to monitor.R32's progress note, dated 3/16/26 at 11:02 AM, states new order was received for Ciprofloxacin (antibiotic) 500 mg (milligrams) every 12 hours for UTI.R32's progress note, dated 3/17/26, documents Ciprofloxacin (antibiotic) was initiated and administered on 3/17/26. Catheter is draining cloudy, yellow urine.R32's current electronic health record does not document ongoing monitoring or any interventions for R32's UTI symptoms from 3/10/26, after R32's UTI symptoms were identified, to 3/17/26, when antibiotic therapy was initiated. R32's physician orders, dated 4/23/26, document Ciprofloxacin (antibiotic) 500 mg (milligrams) every 12 hours for 10 days for a UTI beginning on 3/17/26. R32's Cephalexin 250 mg (milligrams) by mouth daily was ordered to be held from 3/20/26 to 3/26/26.On 4/21/26 at 12:46 PM and 2:45 PM, R32's urinary catheter collection bag was noted to have sediment in the tubing and amber colored urine present in the bag while sitting on the floor.On 4/21/26 at 12:48 PM, R32 stated, My catheter bags must be replaced often because they get holes in them and break. I have had my catheter for a long time and have a history of getting urinary tract infections (UTIs) and experience bladders spasms. I was treated for a UTI actually a few weeks ago and it was very painful in my (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	groin. I know when I am getting a UTI and tell them (facility staff) when I have signs or symptoms, but sometimes it takes them a while to check my urine or start treatment.On 4/21/26 at 2:45, V10/Certified Nursing Assistant (CNA) confirmed R32's urinary collection bag was in contact with the floor and should not be. V10 stated there should be a barrier between the floor and the bag and then proceeded to pick up R32's urinary catheter collection without gloves on and placed a towel underneath.On 4/22/26 at 8:30 AM, V5/CNA and V6/CNA performed catheter care for R32. V6 applied clean gloves and a gown without performing hand hygiene and then proceeded to perform urinary catheter care for R32. V6 confirmed she did not perform hand hygiene before she applied clean gloves and then performed catheter care and stated, I know I am supposed to perform hand hygiene, but I forgot.On 4/23/26 at 1:30 PM, V26/Registered Nurse/Infection Preventionist confirmed urinary catheter bags should be kept off the floor and hand hygiene should be performed prior to applying gloves to prevent catheter-associated UTIs. V26 stated she had not had a conversation with the ordering provider regarding the long-term use of Cephalexin (antibiotic) for R32 and should have.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer bedtime snacks to three of three diabetic residents (R4, R6, R43) reviewed for bedtime snacks in the sample of 64.Findings include: The Snack Protocol policy, not dated, documents snacks are available to all residents during and after kitchen operation hours. Dietary will provide appropriate snacks based on diet order.1. R4 was admitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Atrial Fibrillation, Chronic Congestive Heart Failure, Polyarthritis and Muscle Wasting and Atrophy.The Brief Interview for Mental Status (BIMS) documents R4 is cognitively intact.R4's current care plan documents R4 is at risk for Malnutrition, is an insulin dependent diabetic and is at risk for hypo/hyper glycemic episodes.R4's Vital Signs report includes diet and snack intakes dated 4/6/26 through 4/24/26 and does not indicate snacks were provided/offered or consumed.On 4/21/26 at 2:40 PM and on 4/22/26 at 11:30 AM, R4 stated nighttime snacks are not offered or received.2. R6 was admitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Small Cell-B Cell Lymphoma, Chronic Lymphocytic Leukemia, Anemia, Atherosclerosis Heart Disease, Polyneuropathy and Muscle Wasting.The Minimum Data Set (MDS) dated [DATE] documents R6 has moderate cognitive impairment.R6's current care plan documents R6's Nutritional Status as at risk for Malnutrition as evidenced by the HNA (Mini Nutritional Assessment).The Dietary Note dated 4/9/26 documents to continue to offer R6 snacks. The Dietary note dated 3/24/26 documents he receives a regular diet, milk shakes twice daily, weight 121 pounds with a significant weight loss of 12 pounds in the past month and to have snacks in room.The Breakfast, AM Snack, Lunch, PM Snack, Dinner, Bedtime Snack, Supplements and Fluids report, dated 1/1/16 through 4/23/26, did not document snacks were provided/offered or consumed.On 4/21/26 at 9:55 AM and on 4/22/26 at 1:25 PM, R6 stated snacks are not offered or received nightly.3. R43 was admitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Atherosclerosis, Ventricular Tachycardia, Chronic Systolic Heart Failure, Ischemic Cardiomyopathy, Osteoarthritis Right Knee and Generalized Anxiety Disorder.The Minimum Data Set (MDS) dated [DATE] documents R43 is cognitively intact.R43's current care plan documents R43 is insulin dependent, is at risk for hypo/hyper glycemic episodes and to monitor effectiveness of current diet and monitor intakes.R43's Nutrition At Risk Report dated 3/25/26 documents for R43 to have Peanut Butter and crackers at 7:00 PM daily.On 4/21/26 at 10:30 AM and on 4/22/26 at 1:20 PM, R43 stated snacks were not offered or received nightly.On 4/23/26 at 2:30 PM, V2 (Director of Nursing) stated snacks are kept in the clean utility closet and residents can have snacks anytime they request them. V2 agreed nighttime snacks should be offered to residents, especially residents with diabetes and those that take insulin.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 an accurate medical record for three of three residents (R6, R8, R43) reviewed for accuracy of medical records, in a sample of 64. Findings include:The Restorative Nursing Policy, not dated, documents restorative services and the resident's response toward goals will be documented as follows by staff implementing the plan on one or more of the following forms: Restorative Documentation Record, Nursing Progress Notes, ADL (Activities of Daily Living) Record and/or Treatment Administration Record.The Range of Motion Exercises (ROM) policy, not dated, documents the following information should be documented in the record: date and time exercises were conducted, name and title of who performed the procedure, type of ROM exercises given, how long the exercises were conducted, the signature and title of who recorded the data.1. R6 was admitted on [DATE] with diagnoses of Polyneuropathy, Type 2 Diabetes Mellitus, Small Cell-B Cell Lymphoma, Chronic Lymphocytic Leukemia, Anemia, Atherosclerosis Heart Disease and Muscle Wasting.The Minimum Data Set (MDS) dated [DATE] documents R6 has moderate cognitive impairment.R6's Physician's Order dated 4/17/26 documents R6 will perform active range of motion, two sets of 15 repetitions three times daily and report pain, intolerance, and/or muscle spasm during active range of motion to the nurse.On 4/22/26 at 9:55 AM, R6 stated ROM exercises were not provided by the facility, and he had not received ROM exercises since admission.R6's Nursing Rehab (Rehabilitation) Time Log dated 4/17/26 through 4/22/26 documents R6 received active range of motion exercises two to four times daily by Certified Nurse Aides. The log documented V7 (Certified Nurse Aide/CNA) conducted active range of motion exercises on 4/22/26 at 9:01 AM.2. R8 was admitted on [DATE] with diagnoses of Rheumatoid Arthritis, Type 2 Diabetes Mellitus, Thrombosis Upper Extremity, Major Depressive Disorder and Intervertebral Disk Degeneration Lumbar Region.The Minimum Data Set (MDS) dated [DATE] documents R8 is cognitively intact.R8's Physician's Order dated 9/26/25 documents R8 will perform active range of motion, two sets of 15 repetitions three times daily and report pain, intolerance, and/or muscle spasm during active range of motion to the nurse.On 4/22/26 at 10:19 AM, R8 stated ROM exercises were not provided by the facility, and he had not received ROM exercises since admission.The Nursing Rehab (Rehabilitation) Time Log dated 4/9/26 through 4/22/26 documents R8 received active range of motion exercises two to four times daily. The log documents V7 (Certified Nurse Aide/CNA) conducted active range of motion on 4/22/26 at 9:18 AM.3. R43 was admitted on [DATE] with diagnoses of Osteoarthritis Right Knee, Type 2 Diabetes Mellitus, Atherosclerosis, Ventricular Tachycardia, Chronic Systolic Heart Failure, Ischemic Cardiomyopathy and Generalized Anxiety Disorder.The Minimum Data Set (MDS) dated [DATE] documents R43 is cognitively intact.R43's Physician's Order dated 3/31/26 documents R43 will receive two sets of 15 repetitions of Passive Range of Motion to bilateral lower extremities with staff assistance and verbal cues three times daily.The Nursing Rehab (Rehabilitation) Time Log dated 4/9/26 through 4/22/26 documents R43 received range of motion exercises two to four times daily by Certified Nurse Aides. The log documented V7 (Certified Nurse Aide/CNA) conducted passive range of motion exercises on 4/22/26 at 10:17 AM.On 4/21/26 at 10:30 AM, R43 stated ROM exercises were not provided by the facility, and he had not received ROM exercises since admission.On 4/22/26 at 12:49 PM, V7 stated she had not conducted range of motion exercises with R6, R8 or R43 during her shift on 4/22/26. When asked why V7 documented in the electronic record that passive range of motion was conducted with R4 on 4/22/26 at 9:01 AM, R8 on 4/22/26 at 10:17 AM and R43 at 4/22/26 at 9:18 AM, V7 stated she thought dressing the residents was considered range of motion exercises. V7 stated restorative range of motion and walking exercises are conducted by the restorative nurse aides only but the Certified Nurse Aide (CNA) assigned to the residents with range of motion exercises orders document the exercises were completed.On 4/23/26 at 2:15 PM, V17 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Restorative Nurse Aide) stated she documents restorative cares on the Range of Motion Sheet (Nursing Rehab Time Log) but only conducts walking restorative cares, not range of motion exercises.On 4/23/26 at 2:20 PM, V1 (Administrator) stated staff should not be documenting cares which are not performed/completed by the staff member validating the entry and that documenting that cares were conducted when they were not is falsification of documentation that cares were provided and record entry.