STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145405	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Westmont	6501 South Cass Westmont, IL 60559

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review the facility failed to provide certification for the acting Dietary Manager.This applies to all 177 residents receiving dietary services.Findings include:On 11/21/2025 at 12:12 PM, V1 Administrator confirmed 177 residents were receiving dietary service on the survey start date of 11/18/25.On 11/20/2025 at 3:14 PM, V32 Dietary Manager stated he could not find his certification for Food Service Manager certification. V32 stated he must retake the class.On 11/20/2025 at 3:14 PM, V33 Regional Dietary Director stated they are under a new company and the previous company took V32 certificate during the company changeover.V32 provided a Food Handler certificate dated 8/15/2024 valid through 8/15/27.The facility did not have a policy regarding the certification of dietary staff.

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 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 maintain the kitchen in a manner that prevents food borne illness.This applies to all 177 residents receiving dietary services.Findings include:On 11/21/2025 at 12:12 PM, V1 Administrator confirmed 177 residents were receiving dietary service on the survey start date of 11/18/25.On 11/18/2025 at 10:10 AM, the kitchen tour was conducted with V32 Dietary Manager and V33 Regional Dietary Director.The high temperature dishwasher was run. The testing strip used was labeled to indicated when 160-degree Fahrenheit was attained. The rinse gauge temperature reached 172-degree Fahrenheit.The walk-in cooler contained:Ham in plastic wrap dated 11/10.A box 31.75 lb. (pound) of raw chicken parts stored over three 5lb bags of scrambled egg product.A sliver facility pan with 11 cooked hamburger patties with an expiration date of 11/17.A 10lb box of wilted wrinkled jalapenos with black spotsA box with 14 rotten limes.The dry storage contained:A dented 6lb 12 oz. (ounce) can of kidney beansA dented 6lb 10oz. can of diced peachesA dented 6lb 9oz. marinara sauceA 50lb bag of rolled oats that was open to airA 25lb bag of corn meal that was open to air.A 32 oz bag of powdered sugar without any opened on or use by dates.The reach in cooler contained:6 bags with turkey sandwiches with out a label or dates.A facility container with unidentifiable contents dated 11/16/25.The general kitchen contained:Warming plates in a holding bin identified as being clean with debris.The trays on shelving holding brown cereal bowls were coated with a dark sticky substance.The silverware that was on service line identified as being clean had old food debris on them.The knives in the organizer on the wall above the three-compartment sink were soiled with bits of food debris on them.The cookware on storage shelving had grease and food debris on them.The microwave was splattered and dirty.The toaster oven had splatters of a dried brown substance and was covered in crumbs.The mixer not in use was crusty and uncovered.The reach in cooler in the dining room had 7 brown cups of fruit cocktail that were uncovered, unlabeled and undated.On 11/20/2025 at 3:14 PM, V32 Dietary Manager stated dented cans should be separated out of circulation because they could be contaminated. Food items should be properly to prevent contamination. Labeling and dating are important so everyone is aware when food items were delivered / prepared and when they should be discarded. V32 stated the refrigerators are checked twice per week on delivery days for spoiled or outdated items. Serving outdated items like the ham may cause illness. The raw chicken should not have been stored over the scrambled egg product because if it leaked it could contaminate the items underneath and cause illness. The dishwasher should assure the dishware is clean to the items are free of illness causing bacteria. The dishwasher is a high temperature dishwasher and should reach a rinse temperature of 180 degrees so illness causing bacteria are killed. The strips that only reached 160 degrees were not the correct strips to be used. Staff should be monitoring the strip and the temperature gauge to assure the correct temperature is attained and document the reading from the temperature gauge. If there is a problem with the dishwasher, I should be alerted so that I can contact a repair person. We have not been keeping a log for the red sanitizing buckets.The high temperature dish machine log for October and November had 23 days in which the final rinse temperature was less than 180-degrees Fahrenheit.The manufacturers instruction manual for the high temperature dish machine final rinse recommended is 180-195 degrees Fahrenheit.The undated facility policy Sanitizer Buckets states record ppm (Parts Per Million) on sanitation log.The undated facility policy Cleaning Standards states food contact surfaces, nonfood contact surfaces, equipment, pans and utensils must be kept clean at all times. This includes but not limited to free of grease deposits, food residue, dust and other soil accumulation / debris.The undated facility policy air drying tableware and utensils states once the tableware and utensils are sanitized, they are allowed to air dry.The undated facility policy Food Storage states all open products will be sealed to ensure quality and prevent contamination against pests or rodents. Open products are sealed, labeled and dated.The undated facility policy Labeling and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dating leftovers and opened foods shall be clearly labeled with the date food item is to be discarded. Some local health departments also require preparation date.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have interventions in place to prevent a resident from falling from bed. The facility also failed to store all smoking materials and failed to provide supervision to monitor residents for safe smoking. This affects 5 of 5 (R4, R53, R66, R106, R163) residents reviewed for falls and smoking in a sample of 36. The findings include: 1.On 11/20/2025 at 10:43 AM, R4 stated he had fallen out of the bed when he rolled himself over to his right side. R4 stated when he rolled there was nothing in place to keep him from rolling off right side of the bed. R4 stated he had been asking for a rail on the right side of his bed for a while, but none had been provided. On 11/20/2025 at 10:43 AM, V34 CNA (Certified Nursing Assistant) stated she was working the day R4 fell off the bed. V34 stated R4 fell face down on to the floor on the right side of the bed. V34 stated R4 had a right leg amputation prior to his fall. R4 only had a short rail on the left side of the bed. V34 stated the long rail was placed on the bed after the fall. V34 stated R4 did not have bolsters on his bed until today (11/20/25) when V10 Restorative Nurse asked for her assistance to put them on R4's bed. On 11/20/2025 at 10:56 AM, V35 LPN (Licensed Practical Nurse) stated when she was notified of R4's fall she found him face down on the right side of his bed. V35 stated R4 only had one short rail in place on the left side of his bed. V35 did not recall any other fall or positioning devices in place for R4 at the time of his fall. On 11/20/2025 at 11:06 AM, V25 RN (Registered Nurse) stated V10 Restorative Nurse added the bolsters to R4's bed that day (11/20/25). On 11/20/2025 at 2:47 PM, V10 Restorative Nurse stated she applied an overlay with bilateral bolster to R4's bed earlier in the day. V10 stated R4 was assessed in 8/14/25 to have the short rail on the left side prior to his amputation and prior to his fall. V10 stated R4 was not reassessed for bed safety after his right leg amputation in October 2025. V10 stated she did not do a new assessment for R4 until 11/10/25 after R4 fell out of the bed. V10 stated the post fall assessment done 11/10/25 included the long-left side bed rail and bed bolsters. The restorative side rail review dated 8/14/25 and 11/10/25 assessed for the use of 1/2 side rails to enable R4 to attain and maintain his practicable level. R4's 11/8/25 post fall event summary list contributing factors includes low air loss mattress not complimented with appropriate positioning devices. Lack of adequate use or securing of positioning supports (bolsters, alignment devices). R4's care plan for fall risk was updated on 11/08/25 to include wing tip overlay. The facility Policy Side Rails dated 9/2025 states individualized assessment for side rail usage should be completed as soon as possible after admission, readmission, quarterly and with a significant change in condition by the restorative nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 11/18/2025 at 10:22 AM, R53 he goes on smoke breaks. He had a pack of cigarettes with one stick of cigarette under his shirt on his right shoulder. On 11/18/25 at 8:45 AM R53 was in the patio and was smoking. He said he keeps his cigarettes and lighter on him. He said staff does not supervise them during smoking times. He said he does not know what the fire blanket is used for. R53's face sheet documents diagnoses of hemiplegia and hemiparesis, chronic obstructive pulmonary disease, depression, anxiety disorder, schizoaffective disorder, hyperlipidemia and hypertension. MDS (Minimum Data Sheet) dated 9/3/25 documents that he has intact cognitive functions. 3. On 11/19/25 at 1:00 PM, R66 was in her room. She said she was a smoker. R66's cigarette and lighter were in her pocket. On 11/20/25 at 8:45 AM, R66 was seen opening the patio door using a code. She said everyone knows the code but could not remember who gave it to her. She proceeded to light a cigarette. She said she always have her smoking materials with her. She said staff does not supervise them during smoking times. She said she does not know where the fire blanket was and what it is used for. R66's face sheet documents diagnoses of epilepsy, hypertension, depression, anxiety disorder, bipolar disorder, and obesity. MDS dated [DATE] documents she has intact cognitive functions. 4. On 11/18/25 at 12:20 PM, R106 said he is a smoker. He showed that he keeps his pipe and lighter in his pockets. On 11/19/25 at 9:56 AM, R106 was seen going to the patio to smoke. He was observed using a code to open the patio door. There was no staff observed monitoring the residents smoking in the patio. R106's face sheet documents diagnose of osteoarthritis, type II diabetes mellitus, chronic obstructive pulmonary, insomnia, anxiety disorder, depressive disorder, peripheral vascular disease, hyperlipidemia and hypertension. MDS dated [DATE] documents he has intact cognitive functions. Interview with V11 (SSD-Social Services Director) on 11/20/25 at 2:15 PM said there should be staff supervising residents during smoking times. She said staff should also be the one opening the doors with code. She said residents hold onto to their cigarettes but not their lighters. She is not sure if the facility does sweeps to look for lighters in the facility. Interview with V1 (Administrator) on 11/20/25 at 2:30 PM said residents should not have their cigarettes and lighters with them regardless of if they are safe smokers or not. She said they should be surrendered to staff after each smoking time. She said residents should not know the code to the door going to the smoking patio and does not know how residents got them. She said supervision during smoking times should be followed. Facility's Smoking Program Guidelines updated on 8/6/25 states the following: Smoking material will be stored in the Smoking Materials Container, which will be kept with the designated Smoking attendant during scheduled smoking breaks. Staff Responsibilities: Distribute smoking materials at scheduled times. Monitor for: safe smoking behavior, unsafe signs (e.g. burn marks, scavenging butts, inappropriate requests), overall treatment compliance. Prior to re-entry, staff must check patio for: any lingering residents, contraband or discarded materials. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 11/18/2025 at 11:41 AM, R163 was sitting in a wheelchair in his room. R163 stated he was a smoker. R163 had two empty cigarette packs in his room. R163 stated he keeps his cigarettes in his possession. R163 had a red cigarette lighter in his pocket. R163 stated he steals cigarettes from his girlfriend's purse when she visits. On 11/20/25 at 11:29 AM, R163 stated he still had a cigarette lighter in his possession, but social services took all of his cigarettes from him the other day. R163 stated when he goes out to smoke, if he does not have any cigarettes, he borrows from other residents. R163 stated there are times when he loans cigarettes to other residents. R163's admission Record showed R163 was admitted to the facility on [DATE]. R163 had multiple diagnoses which included displaced comminuted fracture of shaft of left femur, diabetes, hemiplegia and hemiparesis, moderate protein calorie malnutrition, seizures. R163's MDS dated [DATE] showed R163 was cognitively intact. R163's Identified Smoker care plan revised date 11/06/25, showed R163 Had been made aware of the rules and guidelines of the smoking program. R163's Safe Smoking Risk assessment dated [DATE], showed Does individual have burn holes in clothes or burns on fingers/fingernails, with a score of yes.

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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 contain and secure resident medications. This applies to 4 of 4 residents (R1, R65, R84, R183) reviewed for medications in a sample of 36. The findings include: 1 1. On 11/18/2025 at 10:50 AM, R84 was not in the room. R84 had a medication cup on the bedside table that contained a white pill and a tan pill. R84's admission Record showed R84 was admitted to the facility on [DATE]. R84 had multiple diagnoses which included Wernicke's Encephalopathy, alcohol abuse, benign prostatic hyperplasia, and weakness. R84's MDS (Minimum Data Set) dated 10/07/25 showed R84 had moderate cognitive impairment. R84's EMR (Electronic Medical Record) showed no orders for medications to be left at the bedside. 2. On 11/18/25 at 2:28 PM, inside R65's drawer there was an Icy Hot original no-mess roll and Visine eye drops. On 11/20/25 at 1:50 PM, R65 stated the medications are always kept in her room because she doesn't want to bother the nurse each time her eyes are dry and whenever she has pain. Review of R1 and R65's POS (Physician Order Sheet) shows no orders for the medications to be at the bedside. OOn 1/20/2025 at 3:52 PM, V2 (DON—Director of Nursing) stated that medications should be locked up when there is no order for it to be at the bedside. She stated, It should be locked up in the medication cart so it can be secured. 3. On 11/18/25 at 10:39 AM, a bottle of Nyamyc Powder with R183's name was on the nightstand in the room. R183's admission Record showed R183 was admitted to the facility on [DATE]. R183 had multiple diagnoses which included major depressive disorder, morbid obesity, dysphagia, dementia, anxiety, and chronic kidney disease. R183's Order Summary Report for November 2025 showed Nystatin Powder, apply to abdominal folds, arms, and groin topically every day shift for wound prevention. R183's MDS dated [DATE], showed R183 had moderate cognitive impairment. R183's EMR showed no orders for medications to be left at the bedside. 4. On 11/18/25 at 2:03 PM, R1 was lying on her bed. R1 has a tracheostomy and is unable to verbalize. On top of dresser, there was a bottle of artificial tears. Facility's policy titled Medication Storage in the Facility titled 6/2025 shows: General: Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to place call lights within reach. This applies to 1 of 1 resident (R31) reviewed for call lights in a sample of 36.The findings include:On November 18, 2025 at 11:33 AM, R31 was lying in bed and said the left side of her body was paralyzed. R31's call light was on the floor on the left side out of her reach. R31 said if she could not reach the call light, she would have to yell out for the CNAs (Certified Nurse Assistant) to get help. R31 said she had asked for the staff to put a clip on the call light so that it could be attached to her sheet. On November 19, 2025 at 8:40 AM, R31 was lying in bed, and her call light and bed remote were on the floor next to the left side of the bed. On November 19, 2025 at 2:57 PM, the call light was on the floor after R31 was provided incontinence care. On November 19, 2025 at 3:45 PM, R31 was heard yelling from her room, CNA? CNA? Upon entering the room, R31 was lying in bed, and the call light and bed remote were on the floor out of reach. R31 said she could not reach the call light and attempts to reach for it. On November 19, 2025 at 3:50 PM, V14 (CNA) said call lights should be placed at the head of the bed on the resident's dominant side. V14 said she would usually clip it on the sheets if the resident was in bed so even if the resident moves, the call light does not fall onto the floor. V14 said R31 could have an accident and fall out of the bed if the call light is out of reach. On November 19, 2025 at 3:52 PM, V15 (CNA) said the call light should not be on the floor and if the call light was not within reach, she would not be heard unless she yelled out for help. V15 said R31 could fall or hurt herself if she tried to reach for it. V15 said the facility should put a pin on the call light. On November 20, 2025 at 1:33 PM, V3 (DON/Director of Nursing) said call lights should be placed within reach. V3 said if the resident was paralyzed on one side, it should be accessible to the working side. V3 said it was not difficult to get a clip for the call light. R31's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hyperlipidemia, vascular dementia, major depressive disorder, anxiety disorder, chronic pain syndrome, and hypertensive heart disease without heart failure. R31's MDS (Minimum Data Set) dated September 18, 2025 shows R31 was cognitively intact. R31 required supervision for eating, partial assistance for oral hygiene and personal hygiene, substantial assistance for shower/bathing, upper and lower body dressing, and dependent on staff for toileting hygiene and putting on/taking off footwear. R31's Call Light Ability Screen dated September 26, 2025 showed R1 was able to use the call light. R31's care plan dated October 21, 2024 showed Promote placement of call light within reach and assess residents' ability to use. The facility's Call Light Response policy revised September 2025 showed Ensure call light is within resident's reach at all times. When the patient or resident is in bed or confined to bed or chair, provide the call light within easy reach of the patient or resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) care to residents who were dependent on staff for care. This applies to 2 of 2 residents (R31, R11) reviewed for ADLs in a sample of 36.The findings include: 1. On November 18, 2025 at 11:33 AM, R31 said the staff do not cut her nails and she did not receive shower. R31's hair was greasy, and her nails were 0.5 to 0.75 inches long. R31 said she wanted her nails cut short and really wanted a shower. R31's left hand was contracted, and her nails were long. R31 said the staff were supposed to get her dressed and in her chair for breakfast, which they never did. R31 said she was supposed to be in the dining room. R31 said she did not remember the last time she was taken out of bed. R31 said she had requested to be ready to go to mass on Sundays, but they do not get her ready in time to go. On November 19, 2025 at 8:40 AM, R31 was lying in bed and said she did not get a shower yesterday, and her shower days were Tuesdays and Fridays. R31's nails were still long and her hair was greasy. At 2:25 PM, R31 was lying in bed and her nails were still long and she said she still had not received a shower. R31 said she did not remember the last time they cut her nails and her left hand hurt because the nails were digging into her skin. R31 said the middle fingernail on her left hand had something wrong with it, and it appeared to have lines across it. On November 19, 2025 at 9:16 AM, R31 told V18 (CNA/Certified Nurse Assistant) and V17 (CNA) she did not receive a shower on November 18, 2025. V18 said it was not her shower day on November 18, 2025. On November 19, 2025 at 3:11 PM, V17 (CNA) said R31's nails should be cut short because they can get dirty or hurt themselves with long fingernails. V17 said nails are typically trimmed on shower days. On November 19, 2025 at 3:17 PM, V16 (CNA) said R31 as supposed to get showers on Tuesday and Friday mornings. V16 said residents should not have long nails, and they should be cut down and clean. V16 said R31's nails should not be long and could cut into her skin, especially if her hand is contracted. V16 said R31's hair looked greasy. On November 19, 2025 at 3:36 PM, V15 (CNA) said nails should be cut as needed. V15 said she cared for R31 on Tuesday, November 18, 2025, and R31 had not received a shower, and she did not think it was R31's shower day. On November 19, 2025 at 3:50 PM, V14 (CNA) said R31's nails needed to be clipped and her hair looked oily and needed to be washed. R31's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hyperlipidemia, vascular dementia, major depressive disorder, anxiety disorder, chronic pain syndrome, and hypertensive heart disease without heart failure. R31's MDS (Minimum Data Set) dated September 18, 2025 shows R31 was cognitively intact and required partial assistance for personal hygiene and substantial assistance for showers/bathing. R31's Care Plan dated October 21, 2024 showed ADL: [R31] requires assist with daily care needs with interventions including to Assist resident with ADLs. The facility's Bathing Policy reviewed September 2025 showed All residents are offered a bath or shower at least once per week by the Certified Nursing Assistant. Care of fingers and toenails is part (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the bath. Be certain nails are clean. The facility's Activities of Daily Living policy reviewed September 2025 showed Resident self-image is maintained.showers or baths are scheduled and assistance is provided when required. 2. On 11/18/25 at 1:22 PM, R11 said the nursing care could be better. R11 said she is incontinent of urine and stool and she gets frequent urinary tract infections (UTIs). R11 said she asked her nurse at 11:30 AM to change her and the nurse said someone would come back to change her, but they had yet to come back. After surveyor notified staff R11 had been waiting over 2 hours to receive incontinence care, on 11/18/25 at 1:44 PM, V26 (CNA/Certified Nurse Assistant) said he knew R11 needed to be changed but he was waiting for someone to help him. V26 then went into R11's room and put on a mask and gloves. V26 raised up R11's bed, lowered the head of her bed with her remote, removed pillow from under her legs, and unfastened her brief. V26 then washed R11's front side- bilateral groin and inner labia with one soapy washcloth. V26 (CNA) then turned R11 onto her left side and realized she had a large bowel movement and heavily soiled brief with stool and urine. R11 turned onto her side easily and was able to hold herself on her side with the side rail assistance. Some stool was noted to be dried to R11's buttocks. V26 proceeded to clean R11's backside with a second soapy washcloth and was observed having to scrub/rub harder to remove the crusted stool. A strong smell of urine was noted while resident was turned on her side. V26 was able to complete the care without any other staff assistance. Once incontinent care was completed, R11 said she had been sitting in the urine and stool since 11:30AM when she first asked to be changed. R11's MDS (Minimum data Set) dated 10/21/25 shows her cognition is intact and she is completely dependent on staff for toileting hygiene. R11's POS (Physician Order Sheet) shows from 9/4-9/6 she received intravenous (IV) antibiotics for E. Coli in the urine and from 10/17- 10/21 she received oral and intravenous antibiotics for a urinary tract infection. On 11/20/25 at 1:06 PM, V2 (DON/Director of Nursing) said a reasonable amount of time for it to take for staff to provide incontinence care to a resident in need is 10-15 minutes. R11's Care Plan dated 11/18/21 states she is incontinent of bowel and bladder. Interventions include monitor/document for signs and symptoms of UTI and provide incontinence care as needed. R11's Care Plan dated 9/10/25 states resident has an ADL functional performance deficit related to weakness and limited mobility. Interventions include: resident is incontinent of both bowel and bladder and requires assistance with toileting hygiene.

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Bria of Westmont	6501 South Cass Westmont, IL 60559

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to provide splints as ordered.This applies to 2 of 5 residents (R31, R180) reviewed for splints in a sample of 36. The findings include: 1. 1. On 11/18/25 at 11:27 AM, R180 was lying in bed. He was nonverbal. His right hand was severely contracted. There was no splint or restorative device to his right hand. On 11/19/25 at 10:31 AM, R180 was lying in bed. R180 had no palm protector to his right hand. On 11/20/2025 at 11:37 AM, V10 (LPN—Licensed Practical/ Restorative Nurse) stated that restorative aides and CNA's (Certified Nursing Assistants) are supposed to put the splints on resident to prevent contractures and manage range of motion. R180's face sheet shows diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, contracture, right shoulder. Contracture of right elbow, right wrist, and right hand, and abnormal posture. R180's November POS (Physician Order Sheet) shows an order dated 11/6/25 to apply right hand palm protector on in AM and off in PM. Remove every shift to check for CMS, pain, skin integrity and to provide ADL (Activities of Daily Living) care as tolerated every day and evening shift. R180's care plan dated 5/21/25 shows that he requires the use of a right hand palm protector related to contracture. Goal: R180 will not experience contracture progression as evidenced by continued ability to wear current splints comfortably and without complication. Intervention: Apply right hand palm protect on in AM. Off in PM and remove every shift to check for CMS, pain, skin integrity and to provide ADL care as tolerated. R180's Range of Joint Motion Screen dated 9/24/25 shows he has no fixed or joint mobility on his right shoulder, right elbow, and right wrist. Facility's policy titled Splints (10/25) shows General: Adaptive devices will be used as ordered by the physician to prevent deformities or further contractures. Guideline: 3. Splints will be applied by trained nursing staff according to physician's orders. 2. On November 18, 2025 at 11:33 AM, R31 was lying in bed, and her left hand was contracted and there was no splint/brace/device present. R31 said they had not applied a splint or brace to her hand. On November 19, 2025 at 9:18 AM, R31 did not have a brace or splint on her left hand. At 2:25 PM, R31 did not have a brace on her left hand. On November 20, 2025 at 9:23 AM, R31 did not have a brace on her left hand. On November 19, 2025 at 3:17 PM, V16 (CNA/Certified Nurse Assistant) said R31's left hand was not working and remained close. V16 said she was not sure if R31 needed a brace and did not notice R31 having one. V16 said most of the time when a residents' hand was clenched, they would put a brace on. V16 said restorative put the braces on residents. On November 19, 2025 at 3:36 PM, V15 (CNA) said she was not sure R31 had a brace on her arm. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 20, 2025 at 9:56 AM, V10 (Restorative Director) said the restorative aides bring the braces and splints for the residents. V10 said R31 had a left-hand Wrist Hand Finger Orthosis (WHFO) that should be applied in the morning and removed in the evening. V10 said R31 did not refuse to place the brace/splint. V10 said if the staff do not apply the splint/brace, the residents' hands could get contracted. V10 said if the resident refused, they would educate, communicate with the doctor, and care plan to show refusal. On November 20, 2025 at 1:33 PM, V3 (DON/Director of Nursing) said restorative applies the splints and they should be placed as ordered. R31's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hyperlipidemia, vascular dementia, major depressive disorder, anxiety disorder, chronic pain syndrome, and hypertensive heart disease without heart failure. R31's POS (Physician Order Sheet) showed an order for WHFO splint to left hand on in AM off in PM. R31's MDS (Minimum Data Set) dated September 18, 2025 shows R31 was cognitively intact. R31's Care Plan dated October 31, 2024 showed Splint: [R31] requires the use of splint to [related to] hemiplegia and hemiparesis with interventions including Apply left-hand WHFO hand on in AM off in PM. Encourage resident to assist with applying and removing brace. The care plan did not show R31 refused to use it.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure residents received the physician-ordered amount of tube feeding to prevent weight loss, and failed to ensure a resident's weight loss was identified in a timely manner. This applies to 2 of 2 residents (R19, R31) reviewed for nutrition in a sample of 36.The findings include: 1. R19's POS (Physician Order Sheet) dated November 21, 2025 showed an order for Enteral Feed Order one time a day Enteral Feeding Formula Glucerna 1.2 Rate 75ml/[hour] x 18 [hour] total volume 1350ml starting on November 11, 2025 at 5 PM (which would have it turned off at 11 AM to equal the 18 hours on). On November 18, 2025 at 10:45 AM, R19 was not hooked up to a G-Tube (Gastrostomy) feed and there was a full bottle of tube feeding on the bedside table. R19 appeared thin. On November 19, 2025 at 10:31 AM, R19's feed was paused as she received patient care. At 10:39 AM, V3 (DON/Director of Nursing) came to R19's room to provide wound care and checked how much of the feed was infused, which showed 118 mL (Milliliters). V3 disconnected R19's tube feeding. On November 20, 2025 at 8:52 AM, R19 was lying in bed and her G-tube was not connected. On November 20, 2025 at 9:39 AM, V21 (CNA) and V17 (CNA) weighed R19 using the mechanical lift. R19 weighed 106.8 pounds. On November 20, 2025 at 9:47 AM, V20 (LPN/Licensed Practical Nurse) said she was R19's nurse for the day and had started her shift at 7 AM. V20 said when she saw R19 at 7 AM, her feeding was turned off and not receiving the tube feeding and she disconnected it at 8 AM. V20 said she did not feel R19 had lost weight. V20 said on October 8, 2025, R19 weighed 122.2 pounds and on November 14, 2025, she weighed 107.5 pounds, which was weight loss. V20 said restorative took the residents' weights and entered them into the EMR (Electronic Medical Record). V20 said the restorative staff usually talk to the floor nurses. V20 said if she was aware of the weight loss, she would call the doctor and report the weight loss and get orders. V20 said the dietitian should also be notified. On November 20, 2025 at 9:56 AM, V10 (Restorative Nurse) said R19 had a 7.5% weight loss change from October to November. V10 said R19 was fed through a G-Tube and was NPO (Nothing By Mouth). On November 20, 2025 at 11:55 AM, V13 (Registered Dietitian) said R19 had significant weight loss and they had increased the volume to 1350 mL (Milliliters). V13 said the staff should be following the physician orders for the tube feeding. V13 said if the tube feeding was turned off from 7 AM to 11 AM, she would not receive 360 calories of formula. V13 said if the resident did not get the total volume due, she would not increase in the weight, and it would not be the appropriate calories if they were not administering the tube feeding as ordered. On November 20, 2025 at 1:33 PM, V3 (DON/Director of Nursing) said residents on G-Tube feedings could have weight loss if they were not getting their full feeding through the G-Tube. V3 said if R19 was supposed to start her tube feeding at 5 PM, and the feed ran for 18 hours, it should be turned off earliest at 11 AM. V3 said they would have to stop and pause the feeds for ADL (Activities of Daily Living) care or repositioning. R19's face sheet showed she was admitted to the facility with diagnoses including type 2 diabetes mellitus, dysphagia, aphasia, end stage renal disease, dependence on renal dialysis, and encounter for attention to gastrostomy. R19's Care Plan dated September 30, 2025 showed [R19] is at risk for complications [related to] NPO status and receiving enteral nutrition with interventions including Tube feeding as ordered. R19's Care Plan dated October 6, 2025 showed On tube feeding. Resident is dependent on tube feeding for adequate nutrition support. Low BMI (Body Mass Index) with interventions including Provide tube feeding as ordered. RD (Registered Dietitian) to provide monthly nutritional assessment. Evaluate calorie, protein and fluid needs and adequacy/appropriateness of current feeding regimen. The facility's Weight Management Policy reviewed September 2025 showed Weekly weights will also be done with a significant change of condition, food intake decline that has persisted for more than one week, or with a physician order.All weights, upon completion will be given to the DON or designee to determine a list of reweighs. Once the reweighs have occurred any resident with an unexplained significant weight loss will be discussed during the weekly NARS (Nutritional At Risk Skin) meeting. The DON or designee (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will forward dietary recommendations to the Physician or NP (Nurse Practitioner), DON, or designee will follow up with recommendations within 24-48 hours.2. R31's weight trend showed on October 10, 2025, R31 weighed 123.5 pounds. On November 20, 2025 at 10:49 AM (during the survey), V10 (Restorative Nurse) had struck out a weight taken on November 4, 2025 of 112.5 pounds. On November 20, 2025 at 1:41 PM, V10 said she was not there for the weight taken on November 4, 2025 and she struck it out on November 20, 2025 because she believed it to be a data entry. On November 20, 2025 at 10:16 AM (during the survey), V10 (Restorative Director) weighed R31, and she weighed 117 pounds. On November 20, 2025 at 11:55 AM, V13 (Registered Dietitian) said R31 was re-weighed today but she had not been notified of any significant weight loss prior to today, and she had not seen the resident yet. V13 said R31 weighed 123 pounds in October and was down to 117 pounds, which was a 5.2% weight loss in one month. V13 said she was not notified of any concerns about R31's eating from the staff. V13 said residents should be set up in a seated position to eat. On November 18, 2025 at 11:33 AM, R31 said the facility staff leave her flat when they bring her food. R31 was lying in bed, and her legs were elevated higher than her head. At 11:54 AM, R31 said they do not prop her up when the food comes around and she gets food on her face, and they do not clean it. At 12:10 PM, R31 said they had forgotten to feed her a few times for dinner, and she would text her family to let them know. R31 said her family would call the facility staff and the staff would come to the room and say, they didn't feed you dinner? to which she would say no, and the staff would say oh, sorry. At 12:57 PM, the CNA (Certified Nurse Assistant) takes R31's tray to her room. At 1:02 PM, R31 was lying in bed, with her head of bed between 30 to 45 degrees. R31 had begun eating and there were pieces of food that had fallen on her gown. On November 19, 2025 at 2:25 PM, R31 was lying in bed with the head of her bed between 30 to 45 degrees. R31 said she was left in the lying position for lunch. R31 said she heard there was chili for lunch but ordered a sandwich because it would not be messy for when she ate. R31 said the sandwich did not taste that good, so she did not eat it all. R31 said she thinks she lost a little weight because she was not eating as much as she normally did. R31 said she was eating less because it was hard to eat due to the positioning for meals. R31 said it got messy and she spilled a lot when she was eating. R31 said sometimes she would be placed flat on her back and her tray was up high so it would be hard to eat. R31 said when she was fitted for her chair, she weighed 123.5 pounds. On November 20, 2025 at 9:23 AM, R31 said she had a piece of toast and two hardboiled eggs but was still hungry. On November 19, 2025 at 3:17 PM, V16 CNA (Certified Nursing Assistant) said the head of her bed should be upright so she could be able to reach her food and not choke. V16 said they should boost her up to get her into the seated position. V16 said R31 did tend to have food spilled on her clothes. V16 said when she would collect the meal trays after the residents had eaten, she has seen R31's head of bed not elevated appropriately. V16 said if she saw that, she would not leave her that way. R31's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hyperlipidemia, vascular dementia, major depressive disorder, anxiety disorder, chronic pain syndrome, and hypertensive heart disease without heart failure. R31's MDS (Minimum Data Set) dated September 18, 2025 shows R31 was cognitively intact and required supervision for eating. R31's care plan dated October 18, 2024 showed R31 was at nutritional risk as disease progresses. No care plans were found regarding weight loss which occurred from October 2025 to November 2025. The facility's Activities of Daily Living policy reviewed September 2025 showed Proper positioning for eating is maintained.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to verify gastrostomy tube (G-tube) placement before administering medications and to date/label open gastrostomy tube feedings. This applies to 3 of 3 residents (R148, R180, and R196) reviewed for tube feeding management in the sample of 36. The findings include: 1. On 11/19/2025 at 9:07 AM, V8 (RN/Registered Nurse) placed a stethoscope on R196's abdomen before administering a water flush and medications. V8 did not inject air into the tube and auscultate the abdomen with the stethoscope prior to the initial water flush and medication administration to verify tube placement. V8 also did not aspirate gastric secretions prior to the initial water flush and medication administration to verify tube placement. V8 administered an aspirin, multivitamin, and stool softener via gastrostomy tube. On 11/19/2025 at 9:12 AM, V8 stated tube placement must be verified before administering medications and water flushes. V8 stated she forgot to verify placement. V8 described the normal processes of checking for placement. On 11/20/2025 at 10:09 AM, V3 (DON/Director of Nursing) stated prior to administering medications and water flushes via gastrostomy tube, placement should be verified. V3 stated it is expected that nurses verify placement before administering medications and flushes. V3 stated placement can be verified by auscultating the abdomen and pushing 30 milliliters of air while listening via stethoscope or checking secretions for residual. V3 stated if placement is not verified, residents are at risk for aspiration. R196 admission Record showed R196 was admitted to the facility on [DATE]. R196 had multiple diagnoses which included metabolic encephalopathy, diabetes mellitus, cerebral infarction, dysphagia, and encounter for attention to gastrostomy. R196's Order Summary Report for November 2025, showed Check for placement of G-TUBE using auscultation before administering food/meds/fluids. R196's Tube Feeding care plan dated 11/19/25, showed Check feeding tube residual as ordered. Check tube placement by auscultating air injection every shift. The facility's Gastrostomy and Jejunostomy Tube Placement policy, review date 10/25, showed Check placement by injecting air into the tube and auscultating over the abdomen with a stethoscope for a swishing sound or gently aspirate back, looking for gastric secretions. If no secretions are present, attempt to advance the tube slightly and recheck placement. 2. On 11/18/25 at 10:30 AM, R148 had a bottle Jevity 1.5 half consumed and opened on 11/17/25 and no time written when it was opened. On 11/20.25 at 8:30 AM, R148's Jevity 1.5 bottle was on her nightstand on the right side of her bed. The bottle had 700ml left in it and there was no date of when it was opened. R196 POS showed an order for Jevity 1.5, 355ml bolus three times a day. To be given if R196 eats less than 50% of meal. 3. On 11/18/25 at 11:27 AM, R180 was lying in bed. His g-tube machine was running at 55 ML/HR (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Milliliters per Hour). The feeding was Jevity 1.5 with a kangaroo bag. It was not labeled, dated, timed or initialed by the nurse. On 11/20/2025 at 11:22 AM, V2 (DON—Director of Nursing) stated the g-tube feeding should have the name of the resident, the time it was being administered, the date and initials of the nurse. R180's face sheet shows a diagnosis of encounter for attention to gastrostomy. R180's POS (Physician Order Sheet) shows: Enteral Feed Order in the evening related to unspecified protein-calorie malnutrition, encounter for attention to gastrostomy. Start at 6 PM. Feeding formula Jevity 1.5 at 55 ML/HR until 1210 ML is initiated in 24 hours. 2. On 11/18/25 at 10:18 AM, R196 had a bottle of Nepro 1.8. that was half consumed that was dated opened 11/17/25 but with no time when it was opened. R196's POS (Physician Order Sheet) showed an order for Nepro 1.8 rate 55 ml/hour in the evening to infuse for a total volume of 960. Facility's policy titled Tube Feeding Management (10/2025) shows the following: 10. The tube feeding will be labeled with the resident's name, rate, total volume, date and time hung.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate outpatient appointment scheduling and transportation arrangements for resident. This applies to 1 resident (R45) reviewed for social services in a sample of 36.Findings include:R45's Face sheet shows the following diagnoses: hemiplegia and hemiparesis following cerebrovascular accident affecting the left dominant side, neuromuscular dysfunction of bladder, unspecified protein calorie malnutrition, and encounter for attention to gastrostomy. R45's POS (Physician Order Sheet) shows an order dated 6/17/25 to change indwelling urinary catheter, bag and tubing system as needed when malfunctioning; an order dated 10/17/25 urology referral appointment ASAP; an order dated 11/5/25 for GI consult for removal of G-tube (gastrostomy tube); and an order dated 11/19/25 okay to remove the G-tube. R45's MDS (Minimum Data Set) dated 9/1/25 shows his cognition is intact, he uses a wheelchair and is completely dependent on staff for transfer assistance. R45's Care Plan shows he has had an indwelling foley catheter since at least 1/17/25.On 11/18/25 at 12:04 PM, R45 said he has been in the facility since January 2025 and he has always had trouble getting to his appointments. R45 said he has either been late for the appointment by no fault of his own and it was cancelled, they did not arrange an escort for him, transportation refused to take him with his high back wheelchair, or the facility messed up the date of the appointment and he showed up to the doctor's office a day late. R45 said the facility staff are having to change his foley catheter 1-2 times a month because it gets clogged and he has not made it to a urologist appointment one time since coming to the facility almost a year ago. R45 said he is scheduled for a GI (Gastrointestinal) doctor appointment tomorrow (11/19/25) to have his G-tube removed, and he is worried this appointment will also not go as scheduled. R45 said he has not been told when his next urology appointment is supposed to be scheduled after missing the last appointment.On 11/20/25 at 9:47 AM, V22 (Transportation) said she is the staff member responsible for scheduling resident's doctor appointments, escorts for the appointments, and transportation. V22 provided 4 total Appointment Tracking forms for R45 and V22 said those 4 were the only appointments R45 has had scheduled for the past year. These appointment dates show:January 28th with Urologist,March 13th with Urologist,October 14th with a 2nd Urologist, andNovember 19th with Gastrointestinal doctor.V22 said the only appointment R45 missed was his January 28th Urology appointment and that was due to traffic. V22 said R45 had his Urology appointments on March 13th and October 14th and his Gastrointestinal appointment on November 19th, but the GI doctor was not there so that appointment had to be rescheduled and he was unable to get his G-tube removed. When asked if R45 had an appointment cancelled because of his high back wheelchair, V22 said that was true, the transportation wouldn't transfer him with that wheelchair. V22 said that was a recent appointment, but she didn't have an Appointment Tracking form for it. V22 said she does not keep track of a resident's return time or if the appointments were cancelled for any reason.On 11/20/25 at 10:59 AM, R45 said they messed up his appointment again yesterday and he was unable to get his G-tube removed. R45 said transportation was late picking him up, and he arrived to the appointment 15 minutes late, but the GI doctor still saw him. R45 said the GI doctor didn't do anything, though, because there was another mess up and the doctor who put in his G-tube is the same doctor who needs to take it out. R45 said he is most frustrated that the facility transportation person (V22) doesn't know what is going on and the staff in the facility don't communicate with each other. R45 said all the staff keep asking him what happened and he keeps having to explain to them what went wrong because they don't talk to each other. R45 said they have messed up my appointments so many times, how does [V22] not know that? R45 said he did not see the Urologist on March 13th because that was when he was supposed to be there the day before, March 12th. R45 said he was late for the October 14th Urologist appointment because the staff dressed him late, (continued on next page)

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transportation brought him to the appointment late, and the doctor was already gone for the day. R45 said then there was another Urology appointment after that that he missed because the transportation company arranged was different and would not take him in his high back wheelchair and there was no CNA (Certified Nurse Assistant) to escort him.On 11/20/25 at 2:14 PM, V23 (Urology Medical Assistant) said R45 had Urology appointments scheduled on [DATE]th and March 12th and he was a no show for both. On 11/20/25 at 2:28 PM V24 (Patient Care Access Team for Advocate Call Center) said R45 had a Urology appointment scheduled on October 14th and he was a no show. V24 said he notes say R45 was running 20 minutes late so he was told he needed to reschedule.R45's Nurse's Progress Note dated 1/28/25 at 9:38 AM states writer notified via transportation of cancelled appointment. Appointment and Transportation to be rescheduled. R45's Nurse's Progress Note dated 3/13/25 at 12:15 states resident returned from Urology appointment and informed via escort and transportation that the appointment was yesterday. Writer informed DON (Director of Nursing) and Administrator of the need for rescheduling. There are no nursing progress notes entered in the computer system for R45's Urology appointment on October 14th.On 11/20/25 at 1:06 PM, V2 (DON) said V22 (Transportation) is responsible for the coordination of resident appointments and transportation. V2 said if a resident appointment is missed for any reason, it should be documented in a Nurse's Note and rescheduled per V22.The facility's policy titled, Appointments and Transportation last reviewed 9/2025 states, General: When a resident has an appointment outside of the facility, the staff will make the transportation arrangements. Level of responsibility: Nursing Staff Procedure: 1. Staff nurse or designee will call the place of the appointment to verify the date, time, location.5. If the family is not making transportation arrangements, the staff nurse or designee will call the transportation company (Medicare, ambulance, etc) to set up date and time of the pick-up. The pick-up time should be at least 1 hour prior to the appointment.8. On the day of the appointment, the staff nurse will ensure that the resident is clean and dressed appropriately for the weather.10. If the resident is unable to keep the appointment, it is the staff nurse responsibility to cancel the appointment and reschedule it at the earliest time.