STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145411	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden of Pana	900 South Chestnut Pana, IL 62557

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility to manage pain for 1 of 3 (R3) residents reviewed for pain management in a sample of 41. This failure resulted in R3 experiencing unrelieved horrible pain. Findings include:R3's Care Plan, dated 10/16/2026, documents PAIN: The resident has occasional pain r/t (related to) T2DM (type 2 diabetic), heart disease, BPH (benign prostatic hyperplasia), HTN (hypertension), muscle weakness, HLD (Hyperlipidemia), and calcaneal spur to right foot. It also documents Administer analgesia as per orders. Give 1/2 hour before treatments or care. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate pain relief 30-60 minutes after administering analgesics (depending on route).R3's Minimum Data Set, dated [DATE], documents that R3 has pain. R3's Physician order, dated 9/30/2025, documents Heel Protectors on while in bed.On 2/23/2026 at 10:12 AM observed R3 lying on back in bed on his back with heels on mattress. Observed heel protectors in chair next to bed. From 10:30 AM to 2:00 PM using 15 to 30-minute intervals. R3 was observed laying in the bed on his back with both heels pressing against mattress with heel protectors in chair.On 2/23/2026 at 10:12 AM R3 stated that he had sores and blisters to his legs and heels. R3 stated that he was told by the nurse that the areas are closed but not healed. R3 stated that his heels hurt a lot. R3 stated that the pain is horrible. R3 stated that he couldn't get relief because his heels press on the bed. R3 stated that he can't give me a number but is hurts very much and he is unable to get relief.On 2/23/2026 at approximately 11:40 AM R3 stated that his feet feel better. R3 stated that he had been given some pain medication for his stomach earlier, but it didn't help his heels. R3 stated said that since putting on the heel protector the pain is better. R3 stated that it feels like his feet are on air. He feels nothing.On 2/25/2026 at 8:15 AM observed R3 lying on back in bed on his back with heels on mattress. Observed heel protectors in chair next to bed. At 10:16 AM observed R3 lying on back in bed on his back, heels on mattress with heel protectors in chair next to bed. At 11:02 AM observed R3 lying on back in bed on his back, heels on mattress with heel protectors in chair next to bed. At 11:12 AM the heel protectors were applied to R3's feet.On 2/25/2026 at 11:08 AM V3 (Assistant Director of Nursing/ADON), stated that R3 is to always have the heel protectors on when in bed.On 2/25/2026 12:34 PM V5 (Licensed Practical Nurse) stated that R3 is alert. V5 stated that he does have times when he is forgetful. V5 stated that R3 knows when he is in pain and can communicate his pain accurately. V5 stated that R3 has received a new order for pain.The facility's Pain Assessment and Management Level III Purpose policy documents that The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 2. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0697 Level of Harm - Actual harm Residents Affected - Few	Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview, and record review, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 88 of the 88 days reviewed for December 2025, January 2026, and February 2026. This failure has the potential to affect all 71 residents that resides in the facility. Findings Include: During this investigation was V4 (Regional Nurse) was the only RN in the building. The facility's working schedules and daily staffing sheets were reviewed and documents the following: December 2025, there was no RN scheduled from 12/01/25 through 12/31/25.January 2026, there was no RN scheduled from 01/01/26 through 01/31/26.February 2026, there was no RN scheduled from 02/01/26 through 02/26/26. On 02/26/2026 at 9:21 AM, V23 (Certified Nursing Assistant/CNA), said V2 (Director of Nursing/DON) and V4 (Regional Nurse) are in the facility, but she did not know if they (V2 and V4) were working the floor as a nurse. On 02/26/26 at 9:25 AM, V22 (CNA) stated V2 and V4 are in the facility but didn't know if they worked on the floor. On 02/26/2026 at 9:45 AM, V4 (Regional Nurse) stated that the facility does not have an RN for 8 consecutive hours a day. The facility's policy Staffing, Sufficient, and Competent Nursing, revision date of August 2022, documents Policy Statement Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. It further documents Sufficient Staff 3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident. The facility's CMS 671, dated 02/23/26, documents there is 71 residents in the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 properly store medication and discard expired medication. This failure has the potential to affect all 71 residents residing in the facility.Findings include:On [DATE] at 9:51 AM the 200-hall medication cart was inspected. The medication cart contained the following:1 R23's opened and partially used multidose Novolin FlexPen Injection Solution Pen-injector 100 UNIT/ML. No open date.2. R38's opened and partially used multidose Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML. No open date.3. R68's opened and partially used multidose Toujeo SoloStar 300 UNIT/ML Solution pen-injector. No open date.4. R36's opened and partially used multidose Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Vial. No open date.On [DATE] at 9:55 AM V5 (Licensed Practical Nurse/LPN), stated that on the first date the insulin is accessed and used that date is placed on the multidose vials and pens. V5 stated that the insulins have a shortened expiration date. V5 stated that some are 28 days, and some are 30 days after opening. V5 stated that the open dates let them know when the new expiration or use by date is.On [DATE] at 10:02 AM the facility's Medication Room was inspected. The refrigerator inside the medication room contained:5. An opened and partially used multidose vial of Tuberculin inside a plastic bag. No open date on vial or bag. The bag containing the multidose vial of Tuberculin was dated [DATE]. The multidose vial expiration date was [DATE].On [DATE] at 10:04 AM V4 (Regional Nurse) verified that the multidose Tuberculin Vial was open, in use, and no handwritten date on the vial or the bag. V4 verified that the Tuberculin was expired. V4 stated that the multi dose Tuberculin vial should have a handwritten date on the vial or bag when opened. V4 stated that the medication should be disposed of and not in use.On [DATE] at 1:57 PM V5 stated that the multidose Tuberculin vial in the medication room is a stock medication. V5 stated that the medication can be used for all residents as long as they have an order and is not allergic.The facility's Medication Labeling and Storage policy, dated February 2023, Medication Labeling 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.The facility's Medication Administration policy, dated [DATE], documents that Policy Interpretation and Implementation: 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.The Facility's Long Term Care Facility Application for Medicare and Medicaid (CMS 671) dated [DATE] documents there are 71 residents living in the Facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility kitchen staff failed to calibrate a thermometer prior to taking the temperature of the food. This failure has the potential to affect all 71 residents who reside at the facility. Findings Include:On 02/23/26 at 10:55 AM, V7 (Cook) took the temperature (temp) of the food. V7 did not calibrate the thermometer prior to taking the temps. On 02/23/26 at 10:57 AM, V7 was asked how he calibrates the thermometer. He stated, I have no idea let me go ask. V7 talked with V6 (Dietary Manager) and came back and stated V6 said it can't be calibrated. On 02/24/2026 at 10:00 AM, R23, R35, R5, R46, R21 all stated that the food is cold. On 02/26/26 at 11:20 AM, V6 (Dietary Manager) stated that their thermometers are digital and they do not calibrate them and the only way to calibrate it is to put a new battery in it. The facility's Resident Council Concern Report, dated 02/26/26, documents Department: Dietary eggs this morning was cold. The facility's policy Food Preparation and Service, Revision date November 2022, documents Policy Statement Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. It further documents General Guidelines 4. When verifying food temperatures, staff use a thermometer which is both clean, sanitized, and calibrated to ensure accuracy. The facility's CMS 671, dated 02/23/26, documents there is 71 residents in the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to add identified problem areas and to update care plans in a timely manner for 4 residents of 35 residents (R7, R34, R64, R86) whose care plans were reviewed in the sample of 35.Findings Include:1. R34's Face Sheet, print date of 02/25/26, documents he has diagnoses of but not limited to congestive heart failure (CHF), paroxysmal atrial fibrillation, muscle wasting and atrophy, multiple sites, and unsteadiness on feet. R34's Minimum Data Set (MDS), dated [DATE], documents R34 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 13 out of 15 and he requires partial/moderate assistance with sit to stand, transfer chair/bed-to-chair transfer, and toilet transfers. R34's Care Plan, admission date of 12/05/24, documents R34's review shows moderate risk for falls. Risk factors include use of psychotropic medications, diuretics, incontinence, visual impairment, and cognitive impairment. Interventions include but not limited to 01/01/2026: call don't fall sign placed in room by bed to encourage asking for assistance, 01/02/2026: Resident sent to ER (emergency room) for further treatment. Resident noted to have a UTI (urinary tract infection). Will monitor effectiveness of ABX (antibiotics), 01/02/2026: Therapy room to be kept locked when staff not present 01/06/2026: Pressure pad alarm on at all times, 01/25/2026: 15 minute checks, 01/25/2026: Moved to room closer to nursing desk (created on 02/11/2026), 01/01/2026: Physical assessment, neuro assessment, vital signs obtained, assisted patient back into his bed (all created on 01/12/2026), 01/02/2026: Resident assessed from head to toe. Sent to ER (created 01/12/2026), 12/24/2025: Resident educated on walking slow to prevent falls (01/06/2025). R34's Progress Notes were reviewed and documents he had falls on the following dates: On 12/24/2025 at 1:54 PM, R34 was found sitting in the hallway on the floor. On 01/02/2026 at 12:01 AM, R34 was observed on the ground near his bed. He was on his hands and knees. Shoes off and lined up next to bed. On 01/02/2026 at 10:28 AM, R34 tried getting on the scale in the therapy room by himself and lost his balance and fell. On 01/03/2026 at 02:42 AM, R34 at 6:19 PM he was found sitting on the floor at the end of his bed with his back against the bed. On 01/25/2026 at 02:41 AM, R34 was noted to be on the floor lying on his right side with his back pressed up against the wall at 01:49 AM. R34 said he was trying to use his urinal and fell forward and hit his head off the ground. Resident's head bleeding. Cut above left eye cleaned and local ambulance was called to transfer to the local hospital. 2. R64's Face Sheet, admission date of 12/05/26, documents he has diagnoses of but not limited to localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus and paroxysmal atrial fibrillation. R64's MDS, dated [DATE], documents R64 is severely cognitively impaired with a BIMS of 06 out of (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15 and requires substantial/maximal assistance with sit to stand and chair/bed-to-chair transfer. R64's Care Plan, admission date of 12/05/24, documents R64 is at risk for falls related to (r/t) epilepsy, cognitive impairment, hypertension (HTN), type II diabetes mellitus (T2DM), and use of antidepressants. Interventions include but not limited to 11/11/2025: 15 minute checks (create date 11/28/25), 12/23/2025: R64 sent to ER for further evaluation (create date 01/06/2026), 12/30/2025: Bright yellow Call Don't Fall sign placed in resident room by bed (created 02/11/2026), 01/01/2026: Wheelchair not to be left near bedside when resident is not using it (created 02/02/2026), 01/06/2026: Resident moved to room closer to nursing desk (created 02/11/2026). R64's Progress Notes were reviewed and documents he had falls on the following dates: On 11/12/2025 at 1:27 PM, R64 was trying to transfer himself from his wheelchair (w/c) to his bed and fell to the floor. On 12/23/2025 at 5:36 PM, R64 said he was trying to get into his w/c from his bed and slide out of the bed to the floor. On 12/30/2025 at 8:14 PM, R64 was on the floor in his room between the bed and his w/c in a sitting position with his legs out straight. On 12/31/2025 at 01:30 AM, R64 was on the floor in his room. He was lying in the center of the floor halfway between bed and w/c. Hematoma to right eye noted. On 01/01/2026 at 12:55 PM, R64 was found sitting on his floor. He said he was trying to get from his bed into his w/c and his legs gave out. On 01/06/2026 at 10:25 PM, R64 was found on the floor in his room in a sitting position next to his w/c. On 01/07/2026 at 8:00 AM, R64 was found on the floor by staff. He said he was trying to get from his w/c to bed. R64 then fell again at 9:45 AM and was sent to the local hospital for right shoulder pain. 3. R86's Face Sheet, admission date of 12/23/2025, documents R86 has diagnoses of but not limited to fracture of unspecified part of neck of left femur and malignant neoplasm of unspecified part of unspecified bronchus or lung. R86's MDS, dated [DATE], R86 is cognitively impaired with a BIMS of 06 out of 15 and he is dependent on staff for transfers and sit to stand. R86's Care Plan, admission date of 12/23/2025, documents R86's review shows he is a risk for falls. Risk factors include pain, left femur neck fracture (fx), lung cancer, impaired cognition, psychotropic drug use, and total dependence with activities of daily living (ADLs). Interventions include but are not limited to 01/11/2026: 15-minute checks, 01/12/2026: bed to be kept in low position at all times when in bed and resident moved to room closer to nursing station, 02/22/2026: non-skin cushion add to wheelchair to prevent sliding. Pressure alarm at all times (all created on 02/22/2026). R86's Progress Notes were reviewed and documents he had falls on the following dates: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/11/2026 at 5:43 AM, Staff responded to bed alarm and reported R86 was on the floor next to his bed. On 01/12/2026 at 5:28 AM, R86 was noted to be on the floor this morning at 3:59 AM. He was lying on his back with his feet facing the bed. On 02/22/2026 at 1:00 PM, R86 slipped out of w/c in living room by nurse's station. 4.R7's Face Sheet, print date of 2/25/26, documents R7 has diagnoses including traumatic subdural hemorrhage, dementia, unspecified psychosis, generalized anxiety disorder, chronic myeloid leukemia, osteoporosis, and cerebral infarction. R7's MDS (Minimum Data Set), dated 1/21/26, documents R7 is severely cognitively impaired and has a physical restraint. R7's physician order, dated 7/16/25, documents lap restraint when in wheelchair due to frequent falls and decrease in mobility. Off during meals times. Release every 2 hours. R7's restraint Care Plan documents it was created on 9/11/25. This Care Plan documents device in place, lap restraint related to injury, repeated falls, dementia, poor safety awareness, and unsteady gait. Interventions include apply lap restraint when in wheelchair and release every 2 hours and during meals. Document restraint use and release as per facility protocol. R7's fall intervention for the fall R7 sustained on 6/26/25 was not created/added to her Care Plan until 7/7/25. R7's fall intervention for the fall R7 sustained on 7/2/25 was not created/added to her Care Plan until 7/7/25. On 2/24/26 at 2:37 PM V4 (Regional Nurse) stated the initiated date on the resident Care Plan is when the intervention was put into place and the created date is when the care plan was made/created. Survey asked V4 how soon she expects care plans to be created and V4 stated care plan interventions should be created and initiated immediately or the next day after the fall occurred or the restraint was ordered. V4 stated if the IDT (Interdisciplinary Team) decides a resident needs a restraint, then I would expect the care plan to be updated immediately. Surveyor asked V4 what R7's restraint Care Plan creation date was, V4 looked at R7's care plan creation date and stated it was created on 9/11/25. Surveyor asked V4 if that was an acceptable time frame since V4's restraint was implemented/ordered on 7/21/25 and V4 replied no it is not. The Facility's Care Plans, Comprehensive Person-Center Policy dated 3/2022 documents a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 1. The interdisciplinary team (IDT), in conjunction with the resident, family, or legal representative, develops and implements a comprehensive, person-center care plan for each resident. 2. The comprehensive, person-centered care plan is developed within 7 days of the required MDS assessment. It continues, 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes, b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. It continues, 12. The interdisciplinary team reviews (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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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 implement progressive fall interventions, failed to implement fall reduction interventions in a timely manner, failed to complete post fall assessments per the facility policy, and failed to ensure fall interventions were in place per resident Care Plans for 4 of 10 residents (R7, R34, R64, R86) reviewed for falls in the sample of 35. Findings Include: 1.R7's Face Sheet, print date of 2/25/26, documents R7 has diagnoses including traumatic subdural hemorrhage, dementia, unspecified psychosis, generalized anxiety disorder, chronic myeloid leukemia, osteoporosis, and cerebral infarction. R7's MDS (Minimum Data Set), dated 1/21/26, documents R7 is severely cognitively impaired. R7's Fall Risk Evaluation dated 7/20/23 documents R7 is at risk for falls. R7's Fall Risk Evaluation dated 7/17/25 documents R7 is at risk for falls. On 2/26/26 at 10:53 AM V4 (Regional Nurse) stated R7's fall risk score indicates R7 is at risk for falls. R7's Care Plan, undated, documents resident is at risk for falls related to repeated falls, dementia, incontinence, anxiety, and balance problems. She does not recognize hazardous situation nor her physical limitations. R7's Incident Report dated 6/2/25 documents resident was found in room sitting on bottom in front of bathroom door. Intervention: continue current fall interventions. R7's Incident Report dated 6/7/25 documents resident was ambulating in hallway near a housekeeping cart when she fell. Intervention: housekeeping educated on not leaving carts in walkways. Staff education on making sure resident is wearing proper footwear. R7's Incident Report dated 6/20/25 documents writer was called to unit by CNA (Certified Nursing Assistant) stating that resident had a fall. When writer got to unit to assess resident, resident had gotten up, and started walking around, and when staff tried to approach resident for assessment resident was repeatedly trying to get up and walk. Resident has a laceration above left knee. Steri-strips applied to laceration. It continues, intervention: continue current fall interventions. R7's Incident Report dated 6/26/25 at 8 AM documents resident was ambulating in tv room when she tripped over the leg of another resident's walker. Resident fell to the ground and struck her head. It continues, intervention: resident was sent to (local) ER (Emergency Room) for evaluation and treatment. Resident has a UTI (urinary tract infection) and being treated with oral antibiotics. R7's Incident Report dated 6/26/25 at 3 PM documents resident ambulating in the dining room, then staff seen she was laying on the floor. Resident noted to have purplish discoloration under right eye. Red discoloration on right elbow. Resident c/o (complaint of) facial pain. It continues, resident sent to ER and found to have UTI. R7's Incident Report dated 6/29/25 documents resident found on the hallway floor laying on her (continued on next page)

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Rose Garden of Pana	900 South Chestnut Pana, IL 62557

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stomach with blood coming from open area from bridge of nose and inside nose. Root cause: unaware of safety needs and poor cognition due to advanced dementia. Intervention: medication review and changes as necessary. R7's Incident Report dated 7/2/25 documents resident laying on the floor on her left side. Intervention: continue to monitor effectiveness of ABX (antibiotics) and medication changes. R7's Incident Report dated 7/10/25 at 7:45 AM documents staff seen resident laying in the hallway on her left side. Small purplish discoloration noted to left elbow. Intervention: staff education on keeping walkways clear. R7's Incident Report dated 7/10/25 at 8:05 AM documents R7 was laying on the floor attempting to get up. Intervention: medication review. R7's Incident Report dated 7/15/25 documents staff witnessed resident fall in the dining room. Resident was ambulating when she attempted to walk between a seated resident and her walker. Resident caught the leg of the walker with her foot and fell onto the floor. Resident landed on her left side. Staff went to assess resident and copious amounts of blood loss was coming from resident unable to tell location at this time. Staff log rolled resident on to her back and noted a large laceration on her forehead. Left side of forehead continued to have copious amounts of blood loss, staff applied pressure at this time with a wet towel. Resident continued to stand up while staff attempted to assess her. Staff continued to apply pressure to left forehead. Resident stood herself up and then staff assisted her into a chair. Resident appears to only have forehead laceration, moderate bleeding continued. Resident c/o (complaint of) facial pain. Another nurse was asked to contact EMT'S (Emergency Medical Technicians) for transport to (local) ER. Fall interventions: OT (Occupational Therapy) to evaluate resident for w/c (wheelchair) positioning and use of lap buddy due to decline in resident mobility and safety needs. R7's local hospital record dated 7/15/25 documents diagnosis: 1. Fall, 2. Laceration of head, 3. Dementia. On 2/26/26 at 12:23 PM V4 (Regional Nurse) stated she agrees continue current fall interventions is not a progressive fall intervention. On 2/26/26 at 12:38 PM Surveyor asked V4 if she considers using the same fall intervention for multiple falls acceptable and progressive. V4 replied No. 2. R34's Face Sheet, print date of 02/25/26, documents he has diagnoses of but not limited to congestive heart failure (CHF), paroxysmal atrial fibrillation, muscle wasting and atrophy, multiple sites, and unsteadiness on feet. R34's MDS, dated [DATE], documents R34 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 13 out of 15 and he requires partial/moderate assistance with sit to stand, transfer chair/bed-to-chair transfer, and toilet transfers. R34's Care Plan, admission date of 12/05/24, documents R34's review shows moderate risk for falls. Risk factors include use of psychotropic medications, diuretics, incontinence, visual impairment, and cognitive impairment. Interventions include but not limited to 01/01/2026: call don't fall sign placed in room by bed to encourage asking for assistance, 01/02/2026: Resident sent to ER (emergency room) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for further treatment. Resident noted to have a UTI (urinary tract infection). Will monitor effectiveness of ABX (antibiotics), 01/02/2026: Therapy room to be kept locked when staff not present 01/06/2026: Pressure pad alarm on at all times, 01/25/2026: 15 minute checks, 01/25/2026: Moved to room closer to nursing desk (created on 02/11/2026), 01/01/2026: Physical assessment, neuro assessment, vital signs obtained, assisted patient back into his bed (all created on 01/12/2026), 01/02/2026: Resident assessed from head to toe. Sent to ER (created 01/12/2026), 12/24/2025: Resident educated on walking slow to prevent falls (01/06/2025). R34's Progress Notes were reviewed and documents he had falls on the following dates: On 12/24/2025 at 1:54 PM, R34 was found sitting in the hallway on the floor. On 01/02/2026 at 12:01 AM, R34 was observed on the ground near his bed. He was on his hands and knees. Shoes off and lined up next to bed. 01/02/2026 at 10:28 AM, R34 tried getting on the scale in the therapy room by himself and lost his balance and fell. On 01/03/2026 at 02:42 AM, R34 at 6:19 PM he was found sitting on the floor at the end of his bed with his back against the bed. On 01/25/2026 at 02:41 AM, R34 was noted to be on the floor lying on his right side with his back pressed up against the wall at 01:49 AM. R34 said he was trying to use his urinal and fell forward and hit his head off the ground. Resident's head bleeding. Cut above left eye cleaned and local ambulance was called to transfer to the local hospital. R34's Fall Risk Assessment, dated 12/10/2024, documents R34 is not at risk for falls. R34's Fall Risk Assessment, dated 10/06/2025, documented R34 is at risk for falls. R34's Fall Risk Assessments were reviewed and there was no fall risk assessment completed after his fall on 12/24/25, 01/02/26, 01/03/26, 01/25/26. On 02/25/2026 at 11:40 AM R34 was up and in his wheelchair and there was no pressure alarm on while up in his chair. On 02/26/2026 at 11:51 AM R34's room was inspected and there isn't a call don't fall sign on the wall in his room. 3. R64's Face Sheet, admission date of 12/05/26, documents he has diagnoses of but not limited to localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus and paroxysmal atrial fibrillation. R64's MDS, dated [DATE], documents R64 is severely cognitively impaired with a BIMS of 06 out of 15 and requires substantial/maximal assistance with sit to stand and chair/bed-to-chair transfer. R64's Care Plan, admission date of 12/05/24, documents R64 is at risk for falls related to (r/t) epilepsy, cognitive impairment, hypertension (HTN), type II diabetes mellitus (T2DM), and use of antidepressants. Interventions include but not limited to 11/11/2025: 15 minute checks (create date (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/28/25), 12/23/2025: R64 sent to ER for further evaluation (create date 01/06/2026), 12/30/2025: Bright yellow Call Don't Fall sign placed in resident room by bed (created 02/11/2026), 01/01/2026: Wheelchair not to be left near bedside when resident is not using it (created 02/02/2026), 01/06/2026: Resident moved to room closer to nursing desk (created 02/11/2026). R64's Progress Notes were reviewed and documents he had falls on the following dates: On 11/12/2025 at 1:27 PM, R64 was trying to transfer himself from his wheelchair (w/c) to his bed and fell to the floor. On 12/23/2025 at 5:36 PM, R64 said he was trying to get into his w/c from his bed and slide out of the bed to the floor. On 12/30/2025 at 8:14 PM, R64 was on the floor in his room between the bed and his w/c in a sitting position with his legs out straight. On 12/31/2025 at 01:30 AM, R64 was on the floor in his room. He was lying in the center of the floor halfway between bed and w/c. Hematoma to right eye noted. On 01/01/2026 at 12:55 PM, R64 was found sitting on his floor. He said he was trying to get from his bed into his w/c and his legs gave out. On 01/06/2026 at 10:25 PM, R64 was found on the floor in his room in a sitting position next to his w/c. On 01/07/2026 at 8:00 AM, R64 was found on the floor by staff. He said he was trying to get from his w/c to bed. R64 then fell again at 9:45 AM and was sent to the local hospital for right shoulder pain. R64's Fall Risk Assessment (Admission), dated 12/24/25, documents he is at risk for falls. R64's Fall Risk Assessment (reentry), dated 12/28/25, documents he is not at risk for falls. R64's Falls Risk Assessments were reviewed and there was no fall risk assessment completed after falls on 11/12/25, 12/30/25, 12/31/25, 01/01/26, and 01/07/26. 4. R86's Face Sheet, admission date of 12/23/2025, documents R86 has diagnoses of but not limited to fracture of unspecified part of neck of left femur and malignant neoplasm of unspecified part of unspecified bronchus or lung. R86's MDS, dated [DATE], R86 is cognitively impaired with a BIMS of 06 out of 15 and he is dependent on staff for transfers and sit to stand. R86's Care Plan, admission date of 12/23/2025, documents R86's review shows he is a risk for falls. Risk factors include pain, left femur neck fracture (fx), lung cancer, impaired cognition, psychotropic drug use, and total dependence with activities of daily living (ADLs). Interventions include but are not limited to 01/11/2026: 15-minute checks, 01/12/2026: bed to be kept in low position at all times when in bed and resident moved to room closer to nursing station, 02/22/2026: non-skin cushion add to wheelchair to prevent sliding. Pressure alarm at all times (all created on 02/22/2026). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R86's Progress Notes were reviewed and documents he had falls on the following dates: On 01/11/2026 at 5:43 AM, Staff responded to bed alarm and reported R86 was on the floor next to his bed. On 01/12/2026 at 5:28 AM, R86 was noted to be on the floor this morning at 3:59 AM. He was lying on his back with his feet facing the bed. On 02/22/2026 at 1:00 PM, R86 slipped out of w/c in living room by nurse's station. R86's Fall Risk Assessment (admission), dated 12/23/25, documents he is not at risk for falls. R86's Fall Risk Assessment (full assessment), dated 01/11/26, documents he is at risk for falls. R86's Fall Risk Assessments were reviewed and has no fall risk assessments completed after his falls on 01/12/26 and 02/22/26. The facility's Fall and Fall Risk, Managing, revision date of March 2018, documents Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. It further documents Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. 8. Position-change alarms will not be used as the primary or sole intervention to prevent falls but (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3.If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. The facility's policy Assessing Falls and Their Causes, revision date of March 2018, documents Documentation When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found (e.g., resident found lying on the floor between bed and chair). 2.Assessment data, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4.Notification of the physician and family, as indicated. 5.Completion of a falls risk assessment. 6.Appropriate interventions taken to prevent future falls. 7. The signature and title of the person recording the data. The Facility's CMS 671, dated 02/23/26, documents there are 71 residents in the facility.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure dignity and respect for 4 of 5 (R23, R21, R35 and R46) residents reviewed for call lights in a sample of 35.Findings include: 1.On 02/24/2026 at 2:00 PM, R23 stated that if they don't answer her call light and she has to go to the bathroom and she has an accident it does not feel good and it embarrasses her.R23's Minimum Data Set (MDS), dated [DATE], documented that her cognition was moderately impaired and that she was frequently incontinent of urine and occasionally incontinent of stool. 2. On 02/24/2026 at 2:08 PM, R35 stated that she takes a water pill, and she is always incontinent but if she has to wait, she is just thinking about the other residents that need help and that are not getting it.R35's MDS, dated [DATE], documented that her cognition was intact and that she was frequently incontinent of urine. 3. On 02/24/2026 at 2:12 PM, R21 stated that it takes a long time for the night shift to answer her call light, but she will just get up and go to the bathroom on her own. R21's MDS, dated [DATE], documented that her cognition was intact and that she was occasionally incontinent of urine. 4. On 02/24/2026 at 2:15 PM, R46 stated that if she has to wait a long time and she has to go to the toilet and if she has an accident, it makes her feel awful. R46's MDS, dated [DATE], documented that her cognition was intact and that she was occasionally incontinent of urine. On 2/24/2026 at 4:12 AM, V12 (Licensed Practical Nurse/LPN) stated they usually staff 2 to 3 Certified Nurse Assistants (CNA) for 100, 200, 400 and 1 CNA for the Memory Care unit on night shift. She also stated that she does not feel it is enough CNAs to get everything done, 1 CNA is not enough on the unit.On 2/24/2026 at 4:28 AM, V14 (CNA) stated management does not answer when staff try to contact them. Not even the call nurse's answer. She stated night shift does not have enough staff and they need 5 CNAs on nights (2 on memory unit). On 02/26/2026 at 9:20 AM, V22 (CNA) stated that they try and answer the call lights as soon as possible but if it was her and if she had urinated on herself, she would feel embarrassed.On 02/26/2026 at 9:25 AM, V20 (CNA) that they try and answer the call lights as soon as possible, but she said if she had urinated on herself while waiting for someone to answer her call light, it would embarrass her.On 02/26/2026 at 9:25 AM, V23 (CNA) stated that they try and answer the call lights as soon as possible, but she said if she had urinated on herself while waiting for someone to answer her call light it would embarrass her. The Long-Term Care Ombudsman Program Residents' Right for People in Long Term Care Facilities, undated, documented, Your facility must provide services to keep your physical and mental health, and sense of satisfaction with yourself, at their highest practical levels.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review the facility failed to ensure physical restraints were used to treat a medical symptom, failed to provide evidence of least restrictive methods attempted prior to initiating a physical restraint, failed to identify the amount of time the restraint will be used for, failed to identify risks versus benefits of restraints, failed to provide ongoing monitoring documentation of the restraint, and failed to remove the restraint at meals for 1 of 1 residents (R7) reviewed for physical restraints in a sample of 35. Findings Include: R7's Face Sheet, print date of 2/25/26, documents R7 has diagnoses including traumatic subdural hemorrhage, dementia, unspecified psychosis, generalized anxiety disorder, chronic myeloid leukemia, osteoporosis, and cerebral infarction.R7's MDS (Minimum Data Set), dated 1/21/26, documents R7 is severely cognitively impaired and has a physical restraint.R7's physician order, dated 7/16/25, documents lap restraint when in wheelchair due to frequent falls and decrease in mobility. Off during meals times. Release every 2 hours.R7's Initial/Emergency Use Restraint Evaluation, effective date of 7/17/25, documents lap restraint when in wheelchair d/t (due to) frequent falls and decrease in mobility. Off during mealtimes. Release every 2 hours. This form does not document duration of the restraint application. R7's Care Plan, undated, documents device in place, lap restraint related to injury, repeated falls, dementia, poor safety awareness, and unsteady gait. Interventions include apply lap restraint when in wheelchair and release every 2 hours and during meals. Document restraint use and release as per facility protocol.On 2/24/26 at 9:52 AM R7 was observed sitting in her wheelchair in the Memory Care Unit with a lap restraint on. V19 (Certified Nursing Assistant/CNA) asked R7 to remove/release the lap restraint and R7 did not voice an understanding, nor did she attempt to remove the restraint. V19 then pointed to the lap restraint and asked R7 to remove it. R7 could not release the restraint nor did R7 voice an understanding of the question. On 2/25/26 at 11:50 AM R7 was observed sitting in her wheelchair eating lunch in the memory care unit dining room. R7's lap restraint was observed in use during the meal.On 2/25/26 at 11:55 AM V4 (Regional Nurse) stated restraints are supposed to be removed during meals. On 2/25/26 at 2:56 PM V4 (Regional Nurse) stated she cannot find any restraint reduction attempts nor restraint monitoring documentation for R7.The facility's Use of Restraints policy dated 4/2017 documents restraints shall only be used for the safety and well-being of the resident (s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition and this restricts his/her typical ability to change position or place, that device is considered a restraint. 3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, reclining wheelchair, lap cushions, and trays that the resident cannot remove. It continues, 5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to: a. treat the medical symptom, b. protect the resident's safety; and c. help the resident attain the highest level of his/her physical or psychological well-being. 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. It continues, 9. Restraints shall only be used upon that written order of a physician and after obtaining consent from the resident and/or representative. The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom, and c. The type of restraint, and period of time for the use of the restraint. It continues, 12. The following safety guidelines shall be implemented and documented while a resident is in restraints: a. Restraints shall be used in such a way as not to cause physical injury to the resident and to ensure the least possible discomfort to the resident. b. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. c. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. It continues, 16. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. It continues, 19. Documentation regarding the use of restraints shall include: a. full documentation of the episode leading to the use of the physical restraint. This includes not only the resident symptoms but also the conditions, circumstances, and environment associated with the episode, b. a description of the resident's medical symptoms, c. how the restraint use benefits the resident by addressing the medical symptom; d. the type of the physical restraint used; e. the length of effectiveness of the restraint time; and f. observation, range of motion, and repositioning flow sheets.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to complete dressing changes and daily skin checks as ordered by the physician for wounds for 1 of 3 residents (R73) reviewed for wounds in a sample of 35. Findings Include: R73's Face Sheet, admission date of 02/24/23, documents R73 has diagnoses of but not limited to rheumatoid arthritis, sepsis, peripheral vascular disease, cellulitis of left lower limb, and atherosclerosis of native arteries of right leg with ulceration of other part of lower leg. R73's Minimum Data Set (MDS), dated [DATE], documents R73 is cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 out of 15 and she is dependent on staff for most of her activities of daily living (ADLs). R73's Care Plan, admission date of 02/24/23, documents R73 has a venous/stasis ulcer of the right medial ankle (08/28/25), non-pressure related blister to left heel. Interventions include but are not limited to document location of wound, amount of drainage, peri-wound area, pain, edema, and circumference measurements weekly, evaluate wound for: Size, depth, margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated, monitor/document/report as needed (PRN) for signs and symptoms (s/sx) of infection, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R73's Physician's Orders, dated 09/24/25, documents Daily skin check every day shift. Document: C=Clear; R=Rash, O=Other, P= Pressure, S= Skin Tear, Document CROPs on Treatment Administration Records (TAR) on Friday. R73's Physician's Orders, dated 10/21/25, documents Right Anterior Lower Leg: Cleanse with normal saline/wound cleanser (NS/WC and pat dry. Apply xerform to wound bed. Cover with abdominal pad (ABD). Wrap leg from toes to knee with kerlix then ace bandage. Change daily and PRN. Every night shift. R73's TAR for the month of December 2025 was reviewed and no documentation daily skin check was completed on 12/05/25, 12/19, and 12/26/25. There was no documentation R73's dressing was completed on 12/01/25 and 12/24/25. R73's TAR for the month of January 2026 was reviewed and no documentation daily skin check was completed on 01/16/26 and 01/23/26 and daily dressing change was completed on 01/30/26. R73's TAR for the month of February 2026 was reviewed and no documentation daily skin check was completed on 02/06/26 and 02/20/26 and daily dressing change was completed on 02/06/26 and 02/22/26. On 02/23/2026 at 9:45 AM, R73 is sitting in her wheelchair in her room. The dressing on R73's right lateral ankle has the date of 02/22/26 and there is a moderate amount of yellow/greenish drainage noted to the dressing. On 02/23/26 at 9:40 AM, R73 said her dressing is changed by the night shift usually later in their shift/early in the morning and it wasn't changed last night. She said it was agency staff that was working last night. On 02/24/26 at 4:12 AM, V12 (Licensed Practical Nurse/LPN) said most of the agency nurses don't do their treatments. She said she worked a Saturday night, completed her treatments as ordered, was off Sunday night, then when she worked on Monday night the resident's dressing she applied on Saturday night were still on the residents. On 02/25/26 at 12:38 PM V5 (LPN) stated it's hit or miss if dressings get changed on night shift. She said it depends also if agency staff are working, they are the ones who usually don't do their dressing changes. On 02/26/26 at 3:47 PM, V4 (Regional Nurse) stated she expects dressings to be changed as ordered. The facility's Wound Care Policy, revision date of October 2010, documents Purpose The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Further documents: Documentation The following information should b recorded in the resident's medical record: The following information should be recorded in the resident's medical record:1. The type of wound care given.2. The date and time the wound care was given.3. The position in which the resident was placed.4. The name and title of the individual performing the wound care.5. Any change in the resident's condition.6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145411	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden of Pana	900 South Chestnut Pana, IL 62557

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when inspecting the wound.7. How the resident tolerated the procedure.8. Any problems or complaints made by the resident related to the procedure.9. If the resident refused the treatment and the reason(s) why.10. The signature and title of the person recording the data.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure infection control guidelines were in place and implemented for 2 of 3 (R3, R65) residents reviewed for infection control in a sample of 35. Findings include: 1 R3's Care plan, dated 2/9/2026, documents that R3 is on contact isolation; projected time frame start 11/21/2025 r/t (related to) Infection process ESBL to urine. 2/24/2026 Resident is on contact isolation; r/t Infection process in urine. It continues Isolation Precautions: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry. Educate resident and family on the need of isolation precaution. Educate family and staff regarding the transmission, pathophysiology, etiology, and treatment of infection. Upon gown and glove removal, ensure hands and clothing does not contact potentially contaminated environmental surfaces.R3's Minimum Data Set (MDS), dated [DATE], documents that R3 is cognitively impaired has a catheter and dependent on staff for toileting.R3's sign outside of door documents, Stop Contact precautions everyone must: Clean their hands including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit.On 2/25/2026 at 10:16 AM observed V25 (Certified Nursing Assistant/CNA), and V26 (CNA) entered R3's room. V25 and V26 then washed their hands and applied gloves. V25 and V26 then assisted R3 up in bed. V25 and V26 then removed covers and opened incontinent brief. R3's penis was observed to have a dark red and brown drainage coming from R3's penis and covering the catheter. V25 and V26 then replaced the cover on top of R3. Removed gloves and left room. V25 and V26 did not clean their hands, apply gown and gloves prior to entering room.On 2/25/2026 at 11:02 AM observed V3 (Assistant Director of Nursing/ADON), V25 and V26 applying a gown and gloves outside R3's door. V26 at that time performed catheter care. Using wet wash cloths and foam cleaner V26 cleansed R3's penis and catheter, placing wash cloth on floor then picking it up and handed to V25. V25 then placed the washcloth on the bed. After cleansing the dark red and brown drainage from R3's penis and catheter, using the same soiled gloves V26 applied clean incontinent pad. Using the same soiled gloves V26 assisted R3 with repositioning in bed. Using the same soiled gloves V26 then applied clean sheet over R3, adjusted head of bed touching the remote.On 2/25/2026 at 10:12 AM R3 stated that the staff do not always wear the gowns when providing care for him. R3 stated that the girls clean him but do not wear the gowns. R3 stated that he has an infection in his urine and is on isolation as a result.On 2/26/2026 at 11:15 AM V22 (CNA) stated that gowns, gloves, and mask are worn for residents in isolation and enhanced barrier precautions.2. R65's Care Plan, dated 2/23/2026, documents that Implementation of Enhanced Barrier Precaution due to indwelling medical device are not known to be infected or colonized with any MDRO (Multi drug resistant organism). It also document ensure PPE and alcohol-based hand rub are readily and accessible. Use enhanced barrier protection during high contact care activities, dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting device use central lines, urinary catheter, feeding tube, tracheostomy, wound care.R65's MDS, dated [DATE], documents that R65 is cognitively impaired and totally dependent on staff for toileting.R65's sign outside door documents Stop Enhanced Barrier Precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-contact resident care activities. Dressing, Bathing/showering, changing linens, providing hygiene, changing briefs or assisting with toileting.On 2/25/2026 at 2:15 PM observed V25 (CNA) and V19 (CNA) perform incontinent care on R65. R65 was incontinent of urine. V25 and V19 entered R65's room, performed hand hygiene and applied gloves. V25 and V19 did not perform hand hygiene prior to entering R65's room and did not apply gown. V19 then using wash cloths and foam spray performed incontinent care. V19 changed gloves with each wipe and did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perform hand hygiene. V25 assisted with the removal of R65's urine soiled incontinent brief, urine soiled gown and incontinent brief. With the same urine soiled gloves V25 then applied clean gown, clean incontinent brief, and applied clean covers and placed pillow beneath R65's head manipulating R65's head and face. With the same urine soiled gloves V25 then placed television next to bed. V25 then removed her gloves.On 2/26/2026 at 1:50 PM V25 (CNA) stated that when a resident is on contact isolation or enhanced barrier precautions the PPE is applied at the door prior to entry. V25 stated that this includes when providing incontinent care, catheter care, feeding tubing. V25 stated that linen should not be placed on the floor and hand hygiene should be performed after gloves are removed and before reapplied. The facility's Hand Hygiene policy, updated 8/14/23, documents that All staff will comply with current CDC hand hygiene guidelines to reduce the incidence of health-care associated infections. Indications for hand washing- when hands are visibly soiled or contaminated with blood or other bodily fluids, before and after eating and using the restroom. Handwashing can also be used routinely in the following clinic situations: After contact with bodily fluids, excretions, mucous membranes, non-intact skin and wound dressings 1. Before and after direct resident care 2. Before and after inserting invasive devices 3. When moving from contaminated body site to clean body site during resident care 4. After contact with intact skin 5. After removing gloves Indications for Alcohol Based Hand Rub (ABHR)- When hands are not visibly soiled, ABHR may be used for routinely decontaminating hands in the following clinical situations: 1. Before and after having direct contact with residents 2. Before and after inserting invasive devices that don't require a surgical procedure 3. After contact with a residents' intact skin 4. After contact with inanimate objects (including medical equipment) 5. After removing gloves.