STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145414	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Crossing Lvg & Rehab	409 West Comanche Road Shabbona, IL 60550

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure food was labeled, the sanitation level on the dishwasher was at 50 ppm, dishware and flatware was not used until it was sanitized, and pureed food was at least 135 degrees Fahrenheit on the steam table. This applies to all 52 residents in the facility.The facility's Long Term Care Facility Application for Medicare and Medicaid form dated 1/27/26 showed a census of 52 residents. 1. On 1/27/26 at 9:35 AM, A sign on the refrigerator door stated, refrigerate for safety! cover, label, and date all items. The French toast sticks in the refrigerator were in a bag that was not sealed or labeled. There were 3 resealable storage bags with sliced yellow cheese and sliced ham wrapped in a clear wrap with no labels. There were plastic containers on two drink serving carts with thickener and hot chocolate powder in them that were not labeled. There were two separate plastic containers with lids that contained cereal that were not labeled. On a shelf in the dry storage area there were 4 plates with rice krispie treats wrapped in plastic with no labels. A 22-quart container of brown sugar, 3-liter plastic container of hot cereal mix, and 22-quart plastic containers were on the shelf and did not have labels.On 1/27/2026 at 9:48 AM, V8 Dietary Manager stated food is supposed to be labeled. The item should have the date it was made on it. The other stuff should have the date it was opened on it. V8 stated cheese and lunchmeat should have the best used by date on a label on them. V8 stated it was important to have labels on the food, so they know when it expires.A Daily Task List (no date) for the kitchen staff showed, Everything in the fridge/freezer/storage etc.must be labeled and dated.2. On 1/27/26 at 9:51 AM, V9 Dishwasher was at the low temperature dishwasher running dishes through. V8 Dietary Manager was present when V9 tested the sanitizer level in the machine. V9 used a chlorine test strip, and it showed the level at 10 ppm. V9 stated the chlorine level needed to be at 50 ppm; he stated he checked it that morning. The test was repeated, and the sanitizer level did not reach 50 ppm. V8 manually primed the dishwasher with sanitizer. V8 stated the machine automatically does this but they will manually prime it to get it up to where it needs to be. V8 & V9 tested the sanitizer level again and it did not show any chlorine on the strip. V8 stated he would put a work order in for the dishwasher. V9 continued to run silverware, bowls, and pans through the dishwasher. V6 Dietary aide put the dishes, silverware, and pans away for use.On 1/27/26 at 10:13 AM, the Dish Machine Monitoring Sheet on the clipboard in the kitchen showed the last time the sanitizer level was documented as checked was on 1/25/26 at lunch. There was no documentation for the chlorine on 1/27/26.On 1/27/2026 at 10:15 AM, V8 stated the log sheets should be checked every day and chlorine levels documented three times per day every day. The facility's Low Temp Dishwasher Guidelines (2010) showed, check low temp sanitizer level minimum once a day. Acceptable range 50-100 ppm chlorine. Check local regulations.The facility's Sanitation of Dishes/Dish Machine policy (2017) showed the final rinse sanitization was 50 ppm hypochlorite.The Cleaning Dishes/Dish Machine policy (2017) showed all flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing.3. On 1/27/26 at 12:30 PM, V8 checked the temperature of the pureed food on the steam table for the lunch meal. The sweet (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	potatoes temperature was 131 degrees Fahrenheit - F. At 12:47 PM the pureed food including the sweet potatoes was served for lunch.On 1/28/2026 at 2:47 PM, V5 [NAME] stated the holding temperature for food on the steam table is 135 degrees Fahrenheit. The facility's Food Temperatures policy (2017) showed temperatures should be taken periodically to assure hot foods stay above 135 degrees F and cold foods stay below 41 degrees F during the holding and plating process and until food leaves the service area. Food preparation and service areas will avoid the following methods: a. holding foods in the temperature danger zone (41 degrees to 135 degrees F).

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review the facility failed to provide pureed bread and margarine for the noon meal on 1/27/26 for 8 of 8 residents reviewed (R7, R33, R54, R4, R48, R37, R23, & R43) for dining in the sample of 35 residents.The findings include:The Week 3 Menu for Tuesday showed tater crusted chicken, smoked paprika sweet potatoes, green beans, bread/margarine, and fruit crisp for the noon meal.On 1/27/26 at 12:15 PM, V8 Dietary Manager stated they didn't have the breading to do the tater crusted chicken so the menu was changed, and it would be chicken breast on a bun. On 1/27/26 at 12:47 PM in the kitchen the purees were served up and placed on resident trays. There was no pureed bread placed on the trays.On 1/27/26 for the noon meal R7, R33, R54, R4, R48, R37, R23, & R43 did not receive pureed bread and butter. The residents on a general diet had chicken breasts on a bun.On 1/27/26 at 2:58 PM, V8 stated he forgot the pureed bread. V8 stated he normally would take bread and puree it for the residents and put it on the tray.The facility's Menu Planning policy (2017) showed menus will include at least three meals daily at regular times, in amounts consistent with nutritional needs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 Enhanced Barrier Precautions were followed (R4), failed to ensure hand hygiene was performed during medication pass (R7, R22, R36, R37), and failed to ensure staff did not touch a resident's food with bare hands (R5) for 6 of 6 residents reviewed for infection control in the sample of 35. The findings include:1. R4's face sheet printed on 1/28/26 showed diagnoses including but not limited to senile degeneration of brain, traumatic brain injury, dementia, neuromuscular bladder, and history of urinary tract infection (UTI). R4's facility assessment dated [DATE] showed severe cognitive impairment and staff assistance required for personal hygiene, dressing, and toileting. R4's January 2026 order summary report showed an order for an indwelling urinary catheter start dated 10/8/25. The same report showed R4 placed on enhanced barrier precautions (EBP) with the same start date of 10/8/25. R4's December 2025 medication orders showed an antibiotic start dated 12/5/25 for seven days due to ESBL/UTI infection (Extended-Spectrum Beta-Lactamases bacterial infection). R4's current care plan showed a focus area related to a history of urinary tract infections last revision dated 8/22/2019. The same care plan showed a focus area related to the use of EBP due to an indwelling catheter and a history of ESBL infection last revision dated 1/27/26 (day of survey). On 1/27/26 at 9:49 AM, a sign was posted on the door of R4's room. The sign had a dragonfly on it and handwriting with EBP Bed-1. A PPE bin (personal protective equipment) was located next to the door. R4 was lying in bed one with a blanket over her head. On 1/27/26 at 11:56 AM, this surveyor entered R4's room and V4 (Certified Nurse Aide) was in the process of changing R4's overnight catheter bag to a daytime leg bag. V4 was wearing gloves but not a gown. V4 stated R4 has used a catheter for a long time. It is switched back and forth between bags daily. V4 switched drainage bags then transferred R4 from the bed to the wheelchair. V4 leaned over R4's bed, touching it with her body, and straightening the bed linens. On 1/28/26 at 12:50 PM, V2 (Director of Nurses/Infection Control Preventionist) stated all residents with a catheter are on enhanced barrier precautions. Staff need to wear gowns and gloves during care. Those residents have a high risk of infection due to the opening of a device going into the body. The gowns & gloves are needed as an extra barrier of protection between staff clothing and openings into the body. The PPE stops germs from spreading between resident to resident or getting outside of the room. Staff know who is on EBP because there is a sign with a dragonfly on it and showing which bed is EBP. The facility's Infection Control-Enhanced Barrier Precaution policy last review dated 3/6/25 states: EBP are generally indicated for resident with.ii. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies. The policy further stated: Personal Protective Equipment of gowns and gloves should be donned and worn after entering room and prior to the following high contact resident care activities.f. Device care or use. 2. On 1/28/26 at 7:31 AM, V3 (Licensed Practical Nurse) was observed while performing the morning medication pass for R7, R22, R36, and R37. V3 did not sanitize or wash his hands before the process. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V3 did not sanitize or wash his hands between each resident's medication administration. While V3 was dispensing R22's medication, one tablet fell on top of the medication cart. V3 picked up the tablet with bare hands, placed it in the medication cup, and continued to give it to the resident. V3 did wash his hands after completing the medication pass for the four residents. V3 stated he uses soap and water at completion because he does not like to use the hand sanitizer, he hates it and never uses it. (Hand sanitizer was sitting on the medication cart). On 1/29/26 at 10:05 AM, V1 (Administrator/Register Nurse) stated hand hygiene needs to be done between each resident during a medication pass. Hand hygiene should be done anytime there is the risk of contamination. It prevents the cross contamination of any bacteria or other germs. V1 said medications should be replaced if they are dropped. Using bare hands contaminates the pill. V3 should have replaced the contaminated tablet rather than give it to the resident. V3 should be performing hand hygiene between each resident's medication pass. The facility's Hand Hygiene policy last review dated 3/21/25 states: All personnel working in the long-term care facility are required to wash or sanitize their hands before and after resident contact.after touching inanimate surfaces and objects in the immediate vicinity. The facility's Administering Oral Medications policy last review dated 3/21/25 states: 20. If a medication falls to the floor, discard and document per facility protocol. Repeat the preparation.23. Perform hand antisepsis. 3. R5's admission Record, provided by the facility on 1/29/2026, showed she had diagnoses including, but not limited to Alzheimer's disease, hallucinations, anxiety disorder, anemia, type II diabetes mellitus, heart failure, and chronic kidney disease stage 4. R5's Order Summary Report, provided by the facility on 1/29/2026, showed she was admitted to hospice on 8/6/2025. The report showed R5 had an order for a regular diet. R5's facility assessment dated [DATE] showed she had severe cognitive impairment and required setup or clean-up assistance with eating. R5's ADL (activities of daily living) care plan, with a revision date of 12/10/2025, showed R5 needs supervision to substantial assist with eating and the amount of assistance R5 needs varies. On 1/27/2026 at 1:18 PM, V12 (Certified Nursing Assistant) was setting up R5's lunch meal. V13 picked up R5's bun with his bare hand and covered the bun with mayonnaise. V13 placed the bun back on top of the sandwich and held the bun in place with his bare hand while cutting the bun in half. V13 asked V14 (Certified Nursing Assistant) if she would assist R5 with her meal. V14 pushed the chair she was on from the other side of the table over to R5, sat down and picked up half of the sandwich with her bare hand. V14 held the sandwich up to R5's mouth and R5 took a bite of the sandwich. V14 put the sandwich on the plate and assisted another resident to her right. V14 picked R5's sandwich up again with her bare hands and gave her another bite. On 1/28/2026 at 3:30 PM, V2 (Director of Nursing) said staff do not typically wear gloves when they are feeding the residents. V2 said staff should be cleaning their hands before touching the residents' food. V2 said if staff are moving chairs or feeding other residents, there is the potential for cross-contamination. At 3:47 PM V1 (Administrator) said staff should be using utensils, not their bare hands. For infection control. The facility's policy and procedure titled Assisting the Resident with Meals, with a review date of 3/21/2025, showed 11. Employees must wash their hands before serving food to residents. It is not necessary to wash hands between each resident tray; however, if there is contact with soiled dishes, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clothing or the resident's personal effects, the employee must wash their hands before serving food to the next resident. The policy does not address directly touching the resident's food with bare hands.

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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. Based on interview and record review, the facility failed to consistently obtain daily weights for residents with congestive heart failure (R42, R3) and/or a blood pressure every shift as ordered by the physician following a fall incident (R42). This failure affected 2 of 2 residents (R42, R3) who were reviewed for quality of care in the sample of 35. The findings include: 1. R42's face sheet documented last admission date of 02/04/2025 with a past medical history not limited to fluid overload, frontotemporal neurocognitive disorder, congestive heart failure and history of falling. R42's care plan last reviewed 01/26/2026 showed a fall intervention to monitor blood pressure (b/p's) every shift and update cardiologist of B/P's date initiated 10/06/25. R42's active orders as of 01/28/2026 showed orders to obtain daily weight and notify the cardiologist or provider for weight gain of more than 2-3 pounds over night, or 5 pounds in one week (start date 3/21/2025) every day shift; and obtain blood pressure every shift (start date 10/06/2025). Review of R42's electronic medication administration record (eMAR) and weight/vitals log on 01/29/2026 from October 2025 to current showed the following: October MAR showed no weight documented for the 4th or 28th. October weight log showed no documented weight on the 4th. November MAR showed no documented blood pressure for day shift on the 26th or for the night shift on the 20th or 28th. November blood pressure log showed only one documented blood pressure on the 20th at 1313 and on the 26th at 2244, and only two documented blood pressures for the 28th at 0021 and 1314. December MAR showed no weight documented on the 3rd, 13th or for the 15th through the 17th; and showed no documented blood pressure for day shift on the 5th, 13th 18th and 19th. December weight log showed no documented weight on the 3rd, 13th, or the 15th through the 17th. December blood pressure log showed the same discrepancy on the 5th, 13th and 18th; and only one documented blood pressure on the 19th at 1814. January 2026 MAR showed no weight documented for the 1st, 17th, 20th, 22nd or 29th; and no documented blood pressure for day shift on the 21st or 24th and no documented blood pressure for the night shift on the 21st. January 2026 weight log showed no documented weight on the 1st, 17th, 20th, or the 29th. January 2026 blood pressure log showed the same discrepancy for the 21st, and only one blood pressure logged on the 24th at 1624. On 1/29/2026 at 09:09 AM, R42 was observed in bed. R42 said a few months ago, he was walking in his room with his wheelchair, and he became dizzy then lowered himself to the floor. R42 added that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff started checking his blood pressure 2-3 times a day since the fall. R42 then said he is a daily weight but they have missed a couple of days and they don't always check my blood pressure every shift. On 1/29/2026 at 11:28 AM, V2 (Director of Nursing) said after the nurse enters a weight or blood pressure into the resident's medication administration record (MAR), it will automatically transfer over to the resident's weights/vitals log in their electronic medical record then said, for the most part, R2's weights and blood pressures were logged daily but V2 acknowledged a few missing entries. V2 said is it important to obtain daily weights for a resident with congestive heart failure because we are looking for changes to report to the physician and fall interventions should be followed to prevent further falls. V2 added that it is her expectation that nurses follow physician orders and if resident information is not documented on the MAR, it could be possible that it was not done or was charted somewhere else. (No documentation regarding missing weights or blood pressures was provided) On 01/29/2026, survey team requested policy on obtaining weights for a resident with congestive heart failure and a policy on following physician's orders. Neither policy was received upon survey exit. Medication Orders policy last reviewed 03/21/2025 that was provided by the facility on 01/29/2026 reads in part: the purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. 2. R3's admission Record, provided by the facility on 1/29/2026, showed he had diagnoses including, but not limited to heart failure, Parkinson's disease, dementia, anxiety disorder, depression, restlessness and agitation. R3 was observed on multiple occasions between 1/27/2026 through 1/29/2026. R3 was alert, oriented, and pleasant. No refusals of care were observed by R3. No signs of distress, shortness of breath, or edema noted for R3 during observations. R3's Order Summary Report, provided by the facility on 1/29/2026, showed an active order dated 11/7/2025 for daily weights on Monday, Wednesday, and Friday in the morning due to CHF (congestive heart failure). The order showed a start date of 11/10/2025. The order had no end date. Based on the order, 9 weights should have been entered from 11/10/2025-11/30/2025. Only 4 weights were entered during that time, and they were on 11/10/25, 11/14/25, 11/21/25, and 11/28/25. December should have had 14 weights entered. Only 3 weights were entered for the month of December 2025 and they were on 12/1/25, 12/5/25, and 12/19/25. As of 1/29/2026, 12 weights should have been entered into R3's electronic medical record. Only 1 weight was entered for January 2026 and that was on 1/2/26. R3's January 2026 medication administration record (MAR) and Treatment Administration Record (TAR) did not show any order for weights. On 1/29/2026 at 9:39 AM, V2 (Director of Nursing-DON) looked at R3's electronic medical record and said it looks like there are quite a few missing weights in his medical record. V2 said R3 is on weights three times a week for heart failure. It is important to do the weights as ordered to monitor for changes in edema and fluid buildup. V2 said the CNAs (Certified Nursing Assistants) working that floor the day the weights are scheduled are the ones that get the resident's weight. The nurse is also responsible for making sure the weight gets completed as ordered. V2 was asked to provide the facility's policy and procedure regarding obtaining resident weights/weights for residents with CHF. No policy was provided prior to exiting the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/2026 at 10:18 AM, V11 (Registered Nurse) said the CNAs get the residents' weights and give the weights to the nurses on duty. The nurse enters the weights into the computer on the resident's medication administration record (MAR), and it automatically transfers over to the resident's weights/vitals tab in their electronic medical record.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure catheter tubing was cleansed prior to use (R4) and failed to ensure catheter tubing remained off the floor for 2 of 4 residents (R4, R26) reviewed for catheters in the sample of 35. The findings include: 1. R4's face sheet printed on 1/28/26 showed diagnoses including but not limited to senile degeneration of brain, traumatic brain injury, dementia, neuromuscular bladder, and history of urinary tract infection (UTI). R4's facility assessment dated [DATE] showed severe cognitive impairment and staff assistance required for personal hygiene, dressing, and toileting. R4's January 2026 order summary report showed an order for an indwelling urinary catheter start dated 10/8/25. The same report showed R4 placed on enhanced barrier precautions (EBP) with the same start date of 10/8/25. R4's December 2025 medication orders showed an antibiotic start dated 12/5/25 for seven days due to ESBL/UTI infection (Extended-Spectrum Beta-Lactamases bacterial infection). R4's current care plan showed a focus area related to a history of urinary tract infections last revision dated 8/22/2019. The same care plan showed a focus area related to the use of EBP due to an indwelling catheter and a history of ESBL infection last revision dated 1/27/26 (day of survey). On 1/27/26 at 9:49 AM, a sign was posted on the door of R4's room. The sign had a dragonfly on it and handwriting with EBP Bed-1. A PPE bin (personal protective equipment) was located next to the door. R4 was lying in bed one with a blanket over her head. On 1/27/26 at 11:56 AM, this surveyor entered R4's room and V4 (Certified Nurse Aide) was in the process of changing R4's overnight catheter bag to a daytime leg bag. The leg type drainage bag was lying directly on the used bed linens. V4 wore gloves to disconnect the overnight drainage bag and connect the daytime leg bag. V4 did not sanitize the tubing prior to connecting each of the catheter tubes. V4 stated R4 has used a catheter for a long time. It is switched back and forth between bags daily. On 1/28/26 at 12:49 PM, V2 (Director of Nurses/Infection Control Preventionist) stated the aides should be wiping the tubing before connecting them. An alcohol swab should be used. It is important because it is a relatively sterile field. The alcohol helps to prevent any urinary tract infections. The facility's Urinary Leg Drainage Bags policy last review dated 3/21/25 states under the steps in the procedure section: 4. Wipe the Foley catheter/drainage tubing junction with alcohol wipe before disconnecting. 10. When the urinary leg drainage bag is no longer needed, wipe the catheter/drainage bag junction with alcohol wipe. 11. Wipe connection tip of straight tubing with alcohol wipe. 2. R26's admission Record, printed by the facility on 1/28/2026, showed he had diagnoses including, but not limited to dementia, chronic kidney disease stage 2, a history of urinary tract infections, sepsis, urine retention, and obstructive and reflux uropathy (a structural or functional blockage in the urinary tract that hinders the normal flow of urine and causes urine to flow backward from the bladder to the kidneys). R26's Order Summary Report, printed by the facility on 1/28/2026, showed an active order dated 1/3/2026 for an indwelling urinary catheter for system failure. R26's facility assessment (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE] showed he has severe cognitive impairment, has a urinary catheter, and is frequently incontinent of bowel. The assessment showed R26 is dependent on staff for toilet hygiene and lower body dressing. R26's care plan initiated on 5/8/2025 showed he had a urinary catheter due to a diagnosis of obstructive and reflux uropathy. On 1/27/2026 at 1:08 PM, 1:38 PM and 3:37 PM, R26 was observed sitting in the north dining room at the table. During all three observations, R26's catheter tubing was touching the floor. On 1/28/2026 at 3:30 PM, V2 (Director of Nursing) said catheter tubing should not be touching the floor to prevent cross-contamination. For infection control. At 3:47 PM, V1 (Administrator) said the catheter tubing should not be touching the floor for infection control. The facility's policy and procedure titled Catheters, Emptying a Urinary Drainage Bag, with a review date of 3/21/2025, showed 8. Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145414	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to ensure oxygen tubing was changed weekly for 1 of 2 resident (R18) reviewed for oxygen in the sample of 35.The findings include:On 1/27/26 at 11:16 AM, R18 had an oxygen concentrator in room. The oxygen tubing attached to the concentrator was dated 12/9/25. The humidification bubbler attached to the machine was not dated and half full. On 1/28/26 at 2:14 PM, V1 Administrator stated that oxygen tubing is to be changed weekly for infection control purposes. V1 stated the tubing is changed when the bubblers are running low because it is included in the set up.The Physician Orders dated January 2026 for R18 showed titrate oxygen to maintain oxygen saturation at or above 90%. May administer Oxygen for respiratory distress to maintain O2 saturation as tolerated. The original order was placed 11/19/24 and remained an active order.The Progress Notes for R18 from 12/31/25 through 1/28/26 showed use of oxygen via nasal canula on 12/31/25, 1/2/26, 1/5/26, 1/9/26, 1/12/26, and 1/22/26. On 1/28/26 at 7:41 AM showed the physician was contacted due to R18's continued use of as needed oxygen with desaturations at 87-88% on room air.The Oxygen Vital Sign Record for R18 from 12/16/25 to 1/27/26 showed R18 had oxygen on via nasal cannula on 12/30, 1/1/26, 1/2/26, 1/7/26, 1/9/26 - 1/12/26, 1/14/26, and 1/27/26.R18's Care Plan dated 1/9/26 did not show a plan in place for the use of oxygen including the maintenance of equipment/nasal cannula changes.On 1/28/26 at 2:14 PM, V10 Registered Nurse/Care Plan Coordinator stated if a resident uses oxygen, then they will have a care plan in place for it. V10 looked at R18's care plan and stated she missed putting an oxygen care plan in place for her.The Face Sheet dated 1/28/26 for R18 showed diagnoses including Alzheimer's disease, unsteadiness on feet, atherosclerosis, dementia, restlessness and agitation, hyperlipidemia, hypertension, delirium, and personal history of covid-19.The facility's Oxygen Administration and Storage policy (3/21/25) showed review the resident's care plan to assess for any special needs of the resident. Tubing: Oxygen tubing should be length sufficient to provide the resident with adequate oxygen levels while promoting maximum mobility. Tubing should be changed weekly. Nasal cannula tubing may need to be changed more frequently. Tubing should be kept clean and off soiled surfaces. If contaminated, tubing shall be replaced.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interviews and record review, the facility failed to ensure that prescribed medications were safely administered to a resident as ordered by the physician. This failure affected 1 of 1 resident (R42) reviewed for medication administration in the sample of 35. The findings include:R42's face sheet documented last admission date of 02/04/2025 with a past medical history not limited to lack of coordination, history of falling, muscle weakness, need for assistance with personal care, hypertension, atrial fibrillation and congestive heart failure.On 01/29/2026 at 09:09 AM, entered R42's room and observed a small, clear plastic cup with resident's name written on the cup that contained four tablets. The med cup was on R42's bedside table that was next to his bed. R42 was initially asleep in bed upon entering the room but awoke when surveyor entered. When asked about the medications in the cup, R42 said they always leave my pills there and I take them when I feel like it. R42 then said he did not know what the medications were or why he takes them. R42 added, I should know but I don't. Review of R42's active orders on 01/29/2026 at 09:15 AM (previously requested and received from facility dated 01/28/2026) showed orders not limited to: empagliflozin oral tablet 10 milligram (mg) one tablet by mouth one time a day related to congestive heart failure ; furosemide oral tablet 40mg one tablet by mouth one time a day related to congestive heart failure; lisinopril oral tablet 2.5mg one tablet by mouth one time a day related to hypertension; and metoprolol tartrate tablet give 12.5mg by mouth one time a day for hypertension. Review of R42's electronic medication administration record (eMAR) on 01/29/2026 at 09:15 AM showed the above mentioned medications are scheduled for 08:00 AM daily and were documented as being administered by V11 (Registered Nurse).On 01/29/2026 at 09:19 AM, surveyor entered R42's room with V11 (RN) who said she brought R42 the medications earlier, but he was eating so she left them on the bedside table. V11 added that the medications were scheduled for 08:00 AM. V11 then said that R42 does not have an order to self-administer medications, and she should not have left them at the bedside.Review of R42's medical record showed no active physician's order, and no current assessment or care plan for R42 to self-administrator medications.On 01/29/2026 at 11:23 AM, V2 (Director of Nursing) said she would have to review the policy and procedures for a resident to self-administer medications which should also be care planned. V2 then said she is not aware of any resident who has been assessed to self-administer medications. V2 added that medications should not be left at the bedside because you don't know if the resident will reliably take them and indicated that wandering residents could also be a concern. On 01/29/2026, requested R42's active physician's order to self-administer, and assessment/care plan for medication self-administration from V2 (Director of Nursing) that were not received upon survey exit.Administering Oral Medications last reviewed 03/21/2025 provided by facility on 01/29/2026 reads in part: The purpose of this procedure is to provide guidelines for the safe administration of oral medications. Review the resident's care plan to assess for any special needs of the resident.place the MAR within easy viewing distance, check the label on the medication and confirm the medication name and dose with the MAR, check the medication dose then re-check to confirm proper dose, prepare the correct dose of medication.confirm the identity of the resident, explain the procedure to the resident.offer water to assist the resident in swallowing medications, allow the resident to swallow oral tablets or capsules at his or her comfortable pace.remain with the resident until all medications have been taken.document administration per policy.Self-Administration of Medications policy last reviewed 03/21/2025 provided by V2 (Director of Nursing) on 01/29/2026 reads in part:Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. In addition to general (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's ability to read and understand medication labels, comprehension of the purpose and proper dosage and administration time for his or her medications, ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication, and the ability to recognize risks and major adverse consequences of his or her medications. If the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications.Staff shall identify and give to the charge nurse any medications found at the bedside that are not authorized for self-administration, for return to the facility or responsible party.The staff and practitioner will periodically revaluate a resident's ability to continue to self-administer medications.