STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145419	A. Building B. Wing	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Elmwood Park	7733 West Grand Avenue Elmwood Park, IL 60707

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident's advance directive was followed when determining the type of life sustaining measures provided to the resident. This failure affected one resident (R11) of one resident reviewed for advance directive.Findings include:R11 is [AGE] years old, admitted to the facility on [DATE], face sheet listed the following medical history: Anoxic brain damage, unspecified severe protein- calorie malnutrition, acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, pressure ulcer of sacral region stage 4, tracheostomy status, gastrostomy status, personal history of sudden cardiac arrest, etc. Minimum data Set (MDS) assessment dated [DATE] section C (cognitive patterns) indicated that R11 has severely impaired memory, section GG (functional) of the same assessment indicated that R11 is dependent on staff for all Activities of Daily Living (ADL) care needs.Per record review, R11 did not have any G-tube feeding orders only water flush and medications, the following order, every shift TwoCal HN 50 ml/hr. continuous total volume 1200 ml is consumed. May substitute Jevity 1.5 @ 60 ml/hr. x 24 hrs. if not available total volume to infuse 1440 ml was discontinued [DATE].Care plan initiated [DATE] documented that R11 is on nothing by mouth (NPO) status and is receiving enteral feeding for all nutrition needs. Interventions include adjust tube feeding as needed, monitor tolerance of feeding, monitor weight, labs, skin and hydration, refer to registered dietitian (RD) as needed.Illinois Department of Public health Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form for R11 documented in part, section D: Provide artificial nutrition and hydration by any means, including new or existing surgically placed tubes.On [DATE] at 11:52AM, R11 observed in bed sleeping and unable to awake or respond to any questions. G-tube plunger at bedside, no feeding pump or feeding infusing. [DATE] at 9:50AM, R11 was observed in bed again, still not receiving any feeding. Surveyor inquired about resident's feeing orders from V24 (RN) who said that she is not sure but can find out. At 10:05 after going through several records, V24 said that resident's feeding was discontinued by hospice on [DATE].On [DATE] at 12:35PM, V44 (R11 family member/POA) said that she asked if feeding can be restarted and they said no. V44 has no clinical experience and just went with what hospice told her because resident is at the end of life, and he does not need feeding. V44 said that she would like resident to continue with his feeding.On [DATE] at 10:29AM, V2 (DON) said that the facility collaborates care with the hospice agency and the physicians for residents on hospice care. V2 was not aware that resident's feeding was discontinued and said that no one informed her. V2 added that the facility should follow resident's POLST form in providing care.On [DATE]at 10:52AM, V47 (MD) said she was aware that R11's feeding was stopped by hospice, she was told that it was because of risk of aspiration, it was recommended by hospice and resident's wife was okay with it. V46 added that when a resident is at the end of life, feeding can be stopped, just like chemotherapy and dialysis. V47 said the facility should follow what is in resident's POLST form, if the g-tube feeding is discontinued, the facility needs to readdress the POLST form and get a new one.Advance directive and do not resuscitate (DNR) policy reviewed 9/2023, stated in part: General: When a resident is admitted to the facility, aa discussion of advance (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directives will take place between the resident and family if the resident is unable to make decisions. This enables the staff to readily and clearly ascertain how to treat the residents in advance of an emergency.Advance directives:Under state and federal law, people have the right to make decisions regarding health care treatment. This includes their right to determine in advance what life sustaining treatment will be provided, if any, in the future if they are unable to communicate those desires themselves. However, a resident is not required to be a DNR upon admission.Life sustaining treatments are the measures we take to sustain an individual's life and health. For example, in the event someone suffers a heart attack, we will perform CPR. Further we will take any other measures ordered by the provider, including IV's, tubes and the administration of medications, antibiotics, artificial hydration and nutrition to maintain life unless there are specific directions from the residents and/or family not to.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that staff documented changes in resident's diet orders and failed to notify the dietician of those changes for one resident (R11), failed to maintain professional standards of medication storage, labeling and pharmacy services failed to ensure expired insulin was removed from the active medications in the medication cart for eight (R14, R35, R78, R100, R149, R160, R186, and R187) residents, failed to ensure multi-dose insulin vials and insulin pens were dated upon opening and first use while stored on the medication cart for six (R33, R78, R129, R185, R186, and R189) residents, failed to ensure insulin and an albuterol inhaler without a pharmacy label with the resident's name was removed from the active medications in the medication cart, failed to remove expired stock medication from the medication cart, failed to ensure staff properly document medication administration on the controlled substance record for three (R100, R167, and R175) residents, and failed to ensure a resident's Oxycodone controlled medication was initially documented on an individual controlled substance form for one (R188) resident. These failures have the potential to affect 47 residents on the 2nd floor and 51 residents on the 4th floor reviewed for medication storage and labeling and four (R100, R167, R175, and R188) of four residents reviewed for pharmacy services. Findings include: Medication Storage and Labeling On 03/23/2026 at 11:55 AM, the 2nd floor medication cart side 2 was reviewed with V9 LPN Licensed Practical Nurse. R189 Lispro insulin one vial 100 units/milliliter that is open with no open or expiration date in the top right drawer of the medication cart with other insulin medication. R189 Lantus insulin one vial 100 units/milliliter that is open with no open or expiration date in the top right drawer of the medication cart with other insulin medication. Albuterol Sulfate Aerosol inhaler with no pharmacy label or resident name in the top drawer of the medication cart. 24 loose pills scattered throughout the top two drawers of the medication cart. Lantus Solostar insulin pen 100 units/milliliter with no pharmacy label or resident name and no open or expiration date in the top right drawer of the medication cart. R185 Aspart insulin one vial 100 units/milliliter that was open with no open or expiration date in the top right drawer of the medication cart with other insulin medication. R129 Lantus insulin one vial 100 units/milliliter that was open with no open or expiration date in the top right drawer of the medication cart with other insulin medication. On 03/23/2026 at 12:07 PM, V9 LPN was asked about the medication cart. V9 LPN said, Those were pills just in the cart, they should be thrown out. V9 LPN was asked of R189's insulin the inhaler. V9 said, There's no open date and no box. Insulin should be dated when opened. There's no name on it. V9 was asked about the Lantus insulin pen. V9 said, There's no label or open date on it. V9 was asked of R129 and R185's insulin. V9 said, There's no open dates for it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R189's electronic medical records were reviewed. R189 discharged from the facility on 11/08/2025. R189's November 2025 physician orders state in part: Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject subcutaneously in the morning for DM (Diabetes Mellitus). Inject as per sliding scale: if 150 - 200 = 2 Units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units Over 400 call MD or less than 60, subcutaneously in the morning for DM. Lantus Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 15 unit subcutaneously two times a day for DM. These medications were not removed from the active medications in the cart and returned to the pharmacy. R185's records were reviewed. R185 discharged from the facility on 02/06/2026. R185's November 2025 physician orders state in part: Insulin Aspart Injection Solution (Insulin Aspart). Inject subcutaneously four times a day for high blood sugars. Inject as per sliding scale: if 201 - 250 = 2 Units; 251 - 300 = 4 Units; 301 - 350 = 6 Units; 351 - 400 = 8 Units If BG>400 call MD If BG<200 Do not take additional insulin, subcutaneously four times a day for High Blood Sugars. This medication was not removed from the active medications in the cart and returned to the pharmacy. R129's records were reviewed. R129's current physician orders state in part: Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine). Inject 20 unit subcutaneously at bedtime for diabetes hold for bs (blood sugar) less than 100. On 03/23/2026 at 12:15 PM, the 2nd floor medication cart side 1 was reviewed with V28 LPN. R186 Lantus insulin one vial 100 units/milliliter that was open with no open or expiration date in the top right drawer of the medication cart with other insulin medication. R186 Lispro insulin one vial 100 units/milliliter that was open with no open and dated 1/29 on the vial in the top right drawer of the medication cart with other insulin medication. This insulin is expired. R186 Lispro Kwik Pen insulin 100 units/milliliter that was open with a sticker that states Do Not Use after 11/4 on the pen in the top right drawer of the medication cart. This insulin is expired. R14 Lispro insulin one vial 100 units/milliliter that was open with no open and dated 1/29 on the vial in the top right drawer of the medication cart with other insulin medication. This insulin is expired. R187 Basaglar Kwik Pen insulin 100 units/milliliter that was open with a sticker that states Do Not Use after 2/9/26 on the pen in the top right drawer of the medication cart. This insulin was expired. R187 Lispro Kwik Pen insulin 100 units/milliliter that was open with a sticker that states Do Not Use after 2/6/26 on the pen in the top right drawer of the medication cart. This insulin was expired. Geri-Dryl Liquid Allergy Relief (473 milliliter) stock medication bottle has an expiration date of 02/26. The bottle was located in the third middle drawer of the medication cart. This medication was expired. On 03/23/2026 at 12:28 PM, V28 LPN was asked about R186's insulin. V28 LPN said, R186 is deceased . We haven't taken them (insulin) off the cart. V28 LPN was asked about R14's insulin. V28 said, The date is 1/29 we shouldn't be using it because of the date, it's expired. V28 was asked of R187's insulin and the Geri-Dryl liquid stock medication. V28 said, We shouldn't be using it because of the date. It's expired. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R186's records were reviewed. R186 passed away in the facility on 02/13/2026. R186's February physician orders state in part: Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine). Inject 6 units subcutaneously at bedtime for antidiabetic. Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro). Inject 4 unit subcutaneously three times a day for antidiabetics TID (three times a day) with meals. These medications were not removed from the active medications in the cart and returned to the pharmacy. R14's records were reviewed. R14's current physician orders state in part: Humalog Solution 100 UNIT/ML (Insulin Lispro (Human). Inject 5 unit subcutaneously before meals and at bedtime for diabetes mellitus. R187's records were reviewed. R187 discharged from the facility on 02/01/2026. R187's physician orders state in part: Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine). Inject 5 unit subcutaneously at bedtime for antidiabetic. Insulin Lispro (1 Unit Dial) 100 UNIT/ML Solution pen-injector. Inject as per sliding scale four times daily before meals and at bedtime: 180 - 219 = 4; 220 - 259 = 5; 260 - 299 = 6; 300 - 339 = 7; 340 - 379 = 8; 380 - 399 = 9, for Diabetes Mellitus Call MD if over 400. These medications were not removed from the active medications in the cart and returned to the pharmacy. On 03/23/2026 at 1:10 PM, the 4th floor medication cart side 1 was reviewed with V12 LPN. R78 Lantus insulin one vial 100 units/milliliter was open with no open or expiration date in the top right drawer of the medication cart with other insulin medication. On 03/23/2026 at 1:18 PM, V12 LPN said, There's no open date on it, I didn't open it. We shouldn't have it here. R78 Insulin Aspart one vial 100 units/milliliter that is open. The open date sticker documents 11/21/25. The insulin was in the top right drawer of the medication cart with other insulin medication. This insulin was expired. On 03/23/2026 at 1:21 PM, V12 LPN said, It was opened on 11/21/25, it's expired. R78's records were reviewed. R78's current physician orders state in part: Insulin Glargine Solution 100 unit/ml inject 5 unit subcutaneously at bedtime for diabetes. Insulin Aspart Injection Solution Inject as per sliding scale: if 150 - 200 = 2; 201 - 300 = 3; 301 - 350 = 4; 351 - 400 = 5, subcutaneously before meals related to Type 2 Diabetes Mellitus with Diabetic Neuropathy. R149 Lantus insulin one vial 100 units/milliliter that was open with a sticker that states Do Not Use after 3/17/26. The vial was in the top right drawer of the medication cart with other medication. This insulin was expired. There was a Lantus insulin vial with R149's name written on it in black marker. There was no pharmacy label on the insulin. There was no open or expiration date on the insulin vial. On 03/23/2026 at 1:19 PM, V12 LPN said, It should be thrown out, it's expired. R149 Lispro insulin one vial 100 units/milliliter that was open with a sticker that states Do Not Use after 2/15 – 3/12. The vial was in the top right drawer of the medication cart with other medication. This insulin was expired. On 03/23/2026 at 1:20 PM, V12 LPN said, It should be thrown out after 3/12. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lispro insulin one vial 100 units/milliliter that was open on the cart. There was no pharmacy label or resident name on the vial. There was an expiration date of 02/20/26 handwritten in black marker on the vial. On 03/23/2026 at 1:22 PM, V12 LPN said, There's no label or name and it's expired. R33 Lispro insulin one vial 100 units/milliliter that was open with no open or expiration date in the top right drawer of the medication cart with other insulin medication. On 03/23/2026 at 1:21 PM, V12 LPN said, No open date on it. R100 Lantus Solostar insulin pen that is open in the top right drawer of the medication cart with other insulin medication. The vial has an expiration date of 3/19/26 written on it. On 03/23/2026 at 1:24 PM, V12 LPN said, It expired on 3/19. R149's records were reviewed. R149's current physician orders state in part: Insulin Glargine Subcutaneous Solution 100 UNIT/ML inject 18 unit subcutaneously at bedtime for Diabetic Check the blood sugar. Insulin Lispro Injection Solution 100 unit/ml inject 8 unit subcutaneously with meals related to Type 2 Diabetes Mellitus with Diabetic Neuropathy. R33's records were reviewed. R33's current physician orders state in part: Humalog Solution 100 unit/ml (Insulin Lispro (Human) Inject as per sliding scale: if 180 - 210 = 1; 211 - 260 = 2; 261 - 310 = 3; 311 - 360 = 4; 361+ = 5 Above 361, call MD, subcutaneously with meals for diabetes mellitus. R100's records were reviewed. R100's current physician orders state in part: Insulin Glargine Subcutaneous Solution Inject 12 unit subcutaneously at bedtime for Type 2 Diabetes. Pharmacy supply documents Lantus SoloStar 100 UNIT/ML Solution pen-injector. On 03/23/2026 at 1:31 PM, the 4th floor medication cart side 2 was reviewed with V17 RN. R188 medication blister card with a pharmacy label that had been altered. The name on the medication had been covered up with black marker. R188's name was handwritten in black marker on the medication card. There was no pharmacy medication monitoring/ control record sheet for this medication. The narcotic/controlled medication was being documented on a handwritten sheet of copy paper. The medication card documents Oxycodone HCl tablet 5mg (milligrams) – take one tablet per G-tube every 24 hours as needed for severe pain. On 03/23/2026 at 1:43 PM, V17 RN was asked of the medication and documentation form. V17 RN said, It should be on a control form, we should have changed it. R35 Humulin R insulin one vial 100 units/milliliter that was open in the top right drawer of the medication cart with other insulin medication. The vial had an open date of 2/20/26. The insulin was expired. R160 Lantus insulin one vial 100 units/milliliter that was open in the top right drawer of the medication cart with other insulin medication. The vial had an open date of 2/14/26. The insulin is expired. On 03/23/2026 at 1:44 PM, V17 RN NM was asked of the insulin. V17 RN said, It can be open for three months, that's just coming from me. Nobody told me. I'll discard it. R188's records were reviewed. R188's current physician orders state in part: Oxycodone HCl Oral Tablet 10 MG Give 2 tablet by mouth every 6 hours as needed for pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R35's records were reviewed. R35's current physician orders state in part: Insulin Regular Human Injection Solution 100 UNIT/ML inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 5 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451+ = 12 units, subcutaneously before meals for type II diabetes. R160's records were reviewed and his current physician orders state in part: Lantus Solution 100 UNIT/ML Inject 80 unit subcutaneously at bedtime for diabetes mellitus Hold for blood sugar <100 Call for blood sugar <70 or >350. On 03/25/2026 at 2:17 PM, V2 DON Director of Nursing was asked of medication storage, blood glucose checks, and insulin administration concerns. V2 said, Insulin should be dated at time of opening. Once it's open it's good for 28 days. After that it should be discarded, and another one should be ordered. If a medication didn't have a label call the pharmacy and let them know the resident name wasn't on the medication and who it was for. The medication should not be used. It should be discarded. The night nurses and supervisors are responsible for cleaning the medication carts. It's not acceptable for the medication cart to have loose pills in them. The pills should be discarded, wasted. If insulin has a sticker with a do not use after date it should be discarded after the date. Expired insulin isn't effective. Central supply is responsible for making sure stock medication isn't expired. If it's expired it should be discarded. On 03/25/2026 at 2:25 PM, V2 DON was asked to provide this surveyor with the following facility and pharmacy policies for review, but they were not provided during the survey as requested- medication labeling. The undated pharmacy medications with shortened expiration dates policy states in part: Brand: Humalog - Generic: Insulin Lispro injection - Expiration date: vial/Kwik pen: 28 days after first use. Brand: Lantus/Basaglar - Generic: Insulin Glargine injection - Expiration date: Lantus/Solostar Pen and Basaglar/Kwik pen: 28 days after first use. Brand: Novolog - Generic: Insulin Aspart injection - Expiration date: Vial/Flex pen 28 days after first use. Brand: R – Humulin R Generic: Insulin regular injection - Expiration date: 31 days after first use. The facility reviewed 6/2025 Medication Storage in the Facility policy states in part: General: Medications and biologicals are stored safety, securely, and properly following the manufacture or supplier recommendations. The May 2022 pharmacy Preparation and General Guidelines policy states in part: Policy: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. Procedures: B. Expiration dates: Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to be recorded on multidose vials [on the vial label or an accessory label affixed for that purpose]. At a minimum, the date opened must be recorded. The May 2022 pharmacy Medication Storage in the Facility policy states in part: Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Procedures: C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. I. Medication storage areas are kept clean, will-lit, and free of clutter and extreme temperatures and humidity. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Expiration dating (Beyond-use dating) C. Certain medications or package types, such as multiple dose injectable vials, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. E. The nurse will check the expiration date of each medication before administering it. F. No expired medication will be administered to a resident. G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining. The medication will be destroyed in the usual manner. Pharmacy Services Findings include: On 03/23/2026 at 12:15 PM, the 2nd floor medication cart side 1 was reviewed with V28 LPN Licensed Practical Nurse. The controlled substances check form for 2nd floor medication cart side 1 has multiple missing nurse initials for the shift to shift count of the controlled substances. The following dates have no nurse documentation- 2026 March 7th 3PM-11PM shift nurse on and 11PM-7AM shift nurse off, March 9th 3PM-11PM shift nurse on, March 10th 7AM-3PM shift nurse off and 11PM-7AM shift nurse on, March 11th 7AM-3PM shift nurse on and off and 3PM-11PM shift nurse off , March 22nd 3PM-11PM shift nurse on and 11PM-7AM shift nurse on and off, and March 23rd 7AM-3PM shift nurse on are not signed by the nursing staff. On 03/23/2026 at 12:31 PM, the narcotic medication count for the medication cart side 1 was reviewed with V28 LPN. R175 has Pregabalin 75mg (milligrams) – take one capsule by mouth twice a day for pain. The medication monitoring/control record documents 4 remaining tablets. The medication blister package indicates there are 3 tablets remaining. V28 LPN was asked of R175's medication documentation. V28 said, I didn't sign it out yet. I should sign it when I give it to him. V28 was asked of the controlled substances check form. V28 said, It should be done with the nurses at shift change. On 03/23/2026 at 12:37 PM, the 2nd floor narcotic medication count for the medication cart side 2 was reviewed with V9 LPN. R167 had Clonazepam 1mg (milligrams)- take 1/2 tablet (0.5mg) by mouth twice daily for anxiety. The medication monitoring/control record documents 18 remaining tablets. The medication blister package indicates there are 17 tablets remaining. V9 LPN was asked of R167's medication documentation. V9 said, I gave one this morning, but haven't signed it out yet. On 03/23/2026 at 12:59 PM, the 4th floor narcotic medication count for the medication cart side 1 was reviewed with V12 LPN. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R100 Lacosamide 200mg (milligrams)- take one tablet by mouth twice daily for seizures. The medication monitoring/control record documents 10 remaining tablets. The medication blister package indicates there are 9 tablets remaining. R100 Clobazam 10mg (milligrams)- take one tablet by mouth every 12 hours for seizures. The medication monitoring/control record documents 10 remaining tablets. The medication blister package indicates there are 9 tablets remaining. R100 Lacosamide 200mg (milligrams)- take one tablet by mouth twice daily for seizures. The medication monitoring/control record documents 3 remaining tablets. The medication blister package indicates there are 2 tablets remaining. V12 LPN was asked of R100's medication documentation. V9 said, I didn't sign them out yet. The controlled substances check form for 4th floor medication cart side 1 has multiple missing nurse initials for the shift to shift count of the controlled substances. The following dates have no nurse documentation- 2026 March 1st 7AM-3PM shift nurse off and 3PM-11PM shift nurse on and off, March 2nd 7AM-3PM shift nurse on, 3PM-11PM shift nurse on/off, and 11PM-7AM shift nurse on/off, March 8th 7AM-3PM shift nurse on and 3PM-11PM shift nurse off, March 15th 7AM-3PM shift nurse on and 3PM-11PM shift nurse off, March 23rd 7AM-3PM shift nurse on. On 03/23/2026 at 1:08 PM, V12 was asked about completing the control substances check form. V12 said, At the end of the shift with the nurses. On 03/23/2026 at 1:31 PM, the 4th floor medication cart side 2 was reviewed with V17 RN Registered Nurse. R188 has a medication blister card with a pharmacy label that has been altered. The name on the medication label has been covered up with black marker. R188's name was handwritten in black marker on the medication card. There was no pharmacy medication monitoring/ control record sheet for this medication. The narcotic/controlled medication was being documented on a handwritten sheet of copy paper. The medication card documents Oxycodone HCl tablet 5mg (milligrams) – take one tablet per G-tube every 24 hours as needed for severe pain. On 03/23/2026 at 1:43 PM, V17 RN was asked of the medication and documentation form. V17 RN said, It should be on a control form, we should have changed it. On 03/25/2026 at 2:17 PM, V2 DON Director of Nursing was asked of medication storage. V2 said, If a medication didn't have a label call the pharmacy and let them know the resident name wasn't on the medication and who it was for. The medication should not be used. It should be discarded. When controlled medication is administered it should be signed out on the controlled record sheet. The nurse going off and the nurse coming in are responsible for the controlled count sheet being signed every shift. For accountability for each medication. If a controlled medication doesn't have a controlled count record, we have extra sheets on the units. It's not appropriate to have controlled medication count on copy paper. Because the medication came from pharmacy with a controlled count sheet and blank paper isn't acceptable. On 03/25/2026 at 2:25 PM, V2 DON was asked to provide this surveyor with the following pharmacy policies for review, but they were not provided during the survey as requested- controlled substance medication labeling, administration, and documentation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/2024 reviewed facility controlled substance states in part: General: Medications classified by the FDA as controlled substances have high abuse potential and may be subject to special handling, storage, and record keeping. Responsible party: Nursing Policy: 7. While a controlled substance is in use the nursing staff will maintain the following medication records: 8. Record each dose at the time of administration on the following: 9. MAR (medication administration record) a. Date, b. Time, c. Initial of nurse administering dose, d. If a PRN (as needed) order, document effectiveness. 10. Controlled Substance Count Sheet a. Date, b. Time, c. Signature (which includes minimum of first initial last name. and title) of nurse who administered dose, d. Number of doses remaining. 11. All schedule II controlled substances (and other schedules if facility policy so dictates) will be counted each shift or whenever there is an exchange of keys between off-going and on-coming licensed nurses. The two nurses will: a. Inspect both the drug package and the corresponding count sheet to verify the accuracy of the amount remaining. b. Both nurses will count the number of packages of controlled substances that are being reconciled during the shift/shift count and document on the Shift Controlled Substance Count Sheet. c. Both nurses will count the Controlled Substance count sheets and verify the accuracy of the number of remaining count sheets. d. Both nurses will sign the Shift/Shift Controlled Substance Count Sheet acknowledging that the actual count of controlled substances and count sheet matches the quantity documented. The May 2022 Medication Order pharmacy policy states in part: IB2: Controlled Substance Prescriptions Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations. The Director of Nursing and the contracted consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Procedures: K. Controlled substance medications are dispensed by the provider pharmacy in readily accountable quantities and containers designed for easy counting of contents. The pharmacy will include an individual resident controlled drug record (count sheet) for each controlled substance medication container dispensed to a resident. The failure by nursing to meet the standard of dating insulin upon opening and first use puts residents receiving insulin at significant risk of safety hazard that can led to using expired or contaminated medication. Risks include reduced insulin potency causing high blood sugar (hyperglycemia), potential bacteria growth, and serious infection. The failure of nursing to meet the standard of ensuring a pharmacy label is on the medication puts residents at high risk of medication errors. The failure of nursing to meet the standard of ensuring expired stock medication is not stored with active medications on the medication cart poses significant patient safety risks including ineffective treatment, toxicity, adverse reactions, and bacterial growth. The failure of nursing to meet the standard of ensuring documentation of a controlled substance is a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breach of protocol that can lead to drug diversion, creates an inaccurate medical record, and jeopardizes resident safety through potential overdoses or withdrawal. Failure to ensure documentation of controlled substances can be interpreted as negligence and misappropriation of medication by the DEA (Drug Enforcement Agency) and Board of Pharmacy. R11 is [AGE] years old admitted to the facility on [DATE], face sheet listed the following medical history: Anoxic brain damage, unspecified severe protein- calorie malnutrition, acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, pressure ulcer of sacral region stage 4, tracheostomy status, gastrostomy status, personal history of sudden cardiac arrest, etc. Minimum data Set (MDS) assessment dated [DATE] section C (cognitive patterns) indicated that R11 has severely impaired memory, section GG (functional) of the same assessment indicated that R11 is dependent on staff for all Activities of Daily Living (ADL) care needs. Care plan initiated 4/01/2025 documented that R11 is on nothing by mouth (NPO) status and is receiving enteral feeding for all nutrition needs. Interventions include adjust tube feeding as needed, monitor tolerance of feeding, monitor weight, labs, skin and hydration, refer to registered dietitian (RD) as needed. Per record review, R11 did not have any active G-tube feeding order only water flush and medications, the following order, every shift 2 CalHN 50 ml/hr. continuous total volume 1200 ml is consumed. May substitute Jevity 1.5 @ 60 ml/hr. x 24 hrs. if not available total volume to infuse 1440 ml was discontinued 3/6/2026. On 3/26/2026 at 9:30AM V43 (Dietitian) said that the last time she saw R11 was on 3/3/2026 and he was on G-tube feeding, he was also on hydration therapy on 3/4/2026. V43 said that she was blindsided with this decision, no one notified her that resident's feeding was stopped, most of the time she will make recommendations, but she is not aware of the decision, the floor nurse should have notified her of the changes in resident's diet. On 3/26/2026 at 10:29AM, V2 (DON) said that the hospice staff usually come in and provide care to hospice residents, whatever orders they have should be carried out by the floor nurse and the facility also collaborate with the physicians. V2 said that facility clarifies orders by hospice, the floor nurse that received the feeding orders for R11 should have verified it with the physician, notify dietitian and document the order in resident's record. On 3/26/2026 at 1:25PM, V7 (LPN) said that he received an order to discontinue feeding. V7 said that he just discontinued the feeding, did not document it on the resident's record, did not write any progress note, did not notify the dietitian or the doctor. V7 stated that he should have documented and notified the doctor and dietitian of the changes. Job description for registered nurse and licensed practical nurse (undated) stated in part: Under the direction of the physician, is responsible for total nursing care to all residents on assigned unit during assigned shift including responsibility for delegation of duties, resident nursing care, staff performance and adherence by staff members to facility policies and procedures. Essential duties: 10. Document nursing care rendered, resident response, and all other pertinent and necessary data as outlined in facility policies and procedures.

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F 0684 Level of Harm - 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 provide R1 enteral nutrition as ordered by the physician/dietician, failed to follow the facility's tube feeding management policy, failed to provide nutrition and hydration to R11 as indicated in his Illinois Department of Public health Uniform Practitioner Order for Life-Sustaining Treatment (POLST) form, failed to notify the dietician of changes in resident's diet order, and failed to document those changes in resident's medical record. Applying the reasonable person concept due to R1's severe cognitive impairment and inability to make needs known, a reasonable person would have suffered unnecessary psychosocial harm by the delay of feeding and not abiding by resident's last wishes by feelings of hunger, pain, and headaches. This failure affected two residents (R1, R11) in a sample of 82 residents reviewed for quality of care. Findings include: 1. R11 is [AGE] years old admitted to the facility on [DATE]. R11's face sheet listed the following medical history: Anoxic brain damage, unspecified severe protein- calorie malnutrition, acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, pressure ulcer of sacral region stage 4, tracheostomy status, gastrostomy status, personal history of sudden cardiac arrest, etc. Minimum data Set (MDS) assessment dated [DATE] section C (cognitive patterns) indicated R11 has severely impaired memory, section GG (functional) of the same assessment indicated R11 is dependent on staff for all Activities of Daily Living (ADL) care needs. Care plan initiated [DATE] documented R11 is on nothing by mouth (NPO) status and is receiving enteral feeding for all nutrition needs. Interventions include adjust tube feeding as needed, monitor tolerance of feeding, monitor weight, labs, skin and hydration, give additional fluids by feeding tube as ordered, refer to registered dietitian (RD) as needed, turn and reposition every two hours and as needed. Review of physician order summary for R11 showed the following: Consult with nutritionist to assess rate of feeding due to resident having an episode of emesis (order date [DATE]). Check residual. If greater than AND/OR equal 100 ml hold feeding. If feeding held: Check residual after 1 hour and if residual is still great than or equal to 100 ml notify MD (order date [DATE]). R11 did not have any active G-tube feeding order, only water flush and medications. On [DATE] 11:52AM, R11 observed in bed sleeping and unable to awake or respond to any questions. G-tube plunger at bedside, no feeding pump or feeding infusing. On [DATE] at 9:50AM, R11 was observed in bed again, still not receiving any feeding. Surveyor inquired about resident's feeding orders from V24 (RN) who said she was not sure but could find out. On [DATE] at10:05AM, V24 said that she finally found information about resident's feeding, it was discontinued by hospice on [DATE]. On [DATE] at 12:35PM, V44 (R11 family member/POA) said feeding was stopped because residents were throwing up, hospice came and decided to stop feeding. V44 had asked them if feeding could be restarted and they said no. V44 has no clinical experience and just went with what hospice told her, because resident is at the end of life, he does not need feeding. V44 added R11 does not get any (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	water, just what they give him with medication. R11 is not being turned and repositioned every two hours, staff said he does not need it because he is on a special mattress. On [DATE] at 1:00PM, V45 (RN/Hospice Nurse) said R11 was admitted to hospice on [DATE], V44 (POA) wanted to do comfort measures, no intubation, no curative treatments, no full code. V45 said resident was able to open his eyes last year but currently not showing any progress, he has a new pain medication treatment that is helping now. G-tube feeding was stopped on [DATE], because resident was showing a lot of respiratory distress. R11 was previously getting 2 calories feeding at 50ml/hour with a total volume of 425ml. Hospice discussed how feeding can cause resident respiratory distress with family. Surveyor asked V45 if any other interventions were attempted, like reducing the feeding rate or volume rather than stopping the feeding entirely and V45 said, No, they thought resident was going to pass that week. V45 was asked if she told V44 (POA) R11 is at the end of life and does not need feeding and she said yes, V45 told V44 because it would cause R11 more respiratory distress. V45 was asked how she determined R11 was at the end of life. V45 said' His blood pressure is low, today's reading was 110/50 and heart rate of 110. Department of Public health Uniform Practitioner Order for Life-Sustaining Treatment (POLST) form dated [DATE] documented in part, section D: Provide artificial nutrition and hydration by any means, including new or existing surgically placed tubes. On [DATE] at 9:30AM V43 (Dietitian) said she was blindsided with this decision, no one notified her resident's feeding was stopped, most of the time she will make recommendations, but she is not aware of the decision. Surveyor asked V43 what effect not feeding can have on R11. V43 said because of resident's medical condition, it is hard to say, but without nutrition, resident can have weight loss and will not be getting nourishment. V43 said comfort measures do not include withholding feeding, not feeding the resident at all is 'extreme'. V43 added facility should be following resident's POLST form in determining resident's care. On [DATE] at 10:29AM, V2 (DON) said V2 was not aware that R11's feeding was discontinued and said no one informed her. V2 added the facility should follow resident's POLST form in providing care. On [DATE] at 10:52AM, V47 (MD) said he is familiar with R11, and she is aware R11's feeding was stopped by hospice. V47 was told it was because of risk for aspiration, the longer you feed the resident the longer he lives. Surveyor asked V47 if the feeding was stopped to hasten resident's death and she said she did not give the that order, it was recommended by hospice and resident's wife was okay with it. V47 was informed R11 is [AGE] years old and his POLST form signed by the wife indicated nutrition should be provided by any means, and she said facility should follow what is in the resident's POLST form, if the g-tube feeding is discontinued, the facility needs to readdress the POLST form and get a new one. Advance directive and do not resuscitate (DNR) policy reviewed 9/2023, stated in part: General: When a resident is admitted to the facility, aa discussion of advance directives will take place between the resident and family if the resident is unable to make decisions. This enables the staff to readily and clearly ascertain how to treat the residents in advance of an emergency. Advance directives: 1. Under state and federal law, people have the right to make decisions regarding health care treatment. This includes their right to determine in advance what life sustaining treatment will be (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	provided, if any, in the future if they are unable to communicate those desires themselves. However, a resident is not required to be a DNR upon admission. 2. Life-sustaining treatments are the measures we take to sustain an individual's life and health. For example, in the event someone suffers a heart attack, we will perform CPR. Further we will take any other measures ordered by the provider, including IV's, tubes and the administration of medications, antibiotics, artificial hydration and nutrition to maintain life unless there are specific directions from the residents and/or family not to. Guideline: #3 If changes are needed to the advanced directives, then write void across the old form and initiate a new form with the appropriate information. 2. R1's face sheet documents in part the following diagnoses: acute and chronic respiratory failure, type 2 diabetes, unspecified protein calorie malnutrition, dysphagia, pressure ulcer of right buttock stage 3, personal history of traumatic brain injury, epilepsy, encephalopathy, tracheostomy and gastrostomy status. R1's Minimum Data Set ([DATE]) documents in part R1 is rarely/never understood and is severely impaired for cognitive decision making. Additionally, the minimum data set documents R1 receives 51% or more of R1's nutrition via enteral feeding. R1's care plan documents in part, R1 is at risk of hypoglycemia due to type 2 diabetes ([DATE]). R1 is NPO due to dysphagia, tube feeding will provide approximately 100% of estimated needs, and staff should be monitoring R1's tube feeding tolerance ([DATE]). Additionally, the care plan documents R1 may be at increased risk of abuse due to fragility/weakness, poor cognition, poor communication, and has a goal R1 will be free from mistreatment through the next review ([DATE]). R1's physician orders document in part an active enteral feeding order ([DATE]) for, every shift 2 Cal HN @ 40 ml/hr. x 20 hrs. On at 2 pm Off 10 am via GT if not available, may substitute Jevity 1.5 @ 52 ml/hr. x21 hrs. On at 2 pm Off 11 am R1's dietary evaluation completed by V43 (Registered Dietician) documents in part, PMH includes Tracheostomy, Dysphagia, HTN, Protein-Calorie Malnutrition, Seizure disorder, DMT2, Anemia Diet: NPO GT 2 Cal HN 40 ml/hr. x 20 hrs. On at 2 pm Off 10 am Water flush 300 ml every 4 hrs. (1800 ml) TF volume: 800 ml 1600 kcal 67 gm pro 560 ml fw+1800 ml wf=2360 TF provides 100% of estimated nutritional needs. Ht. 64 [DATE] 143.8 [DATE] 144.5 [DATE] 146.8 [DATE] 139 [DATE] 139.2 [DATE] 146 [DATE] 145.8 [DATE] 142.6 BMI=24.7 Normal range Est needs 65 kg: 1636-1964 kcal (25-30) 65-79 gm pro (1.0-1.2) 1964- 2291 ml (30-35 ml/kg) Weight fluctuates between 139-146$ in 6 mos. BMI within normal range Per nurses note [DATE], feeding held due to vomiting. KUB was done due to abdominal distention ([DATE]) Feeding was resumed [DATE] started as 10 ml/hr. and increased by 10 ml/hr. q 4hrs until goal rate of 40 ml/hr. was reached. No reported/documented feeding intolerance. Dependent on enteral feeding for nutrition support r/t dysphagia. [DATE] BUN 29 FBS 67 Cr 1.1 Na 138 L K 4.7 H/H 12.6/38.8 Skin intact, Hx of pressure ulcer Plan: Current order meets 100% of estimated nutritional needs . On [DATE] at 10:57 AM, R1 was observed lying in bed and was not able to be aroused for questioning. R1's enteral feeding pump was alarming with a FEED ERROR. R1's carton of enteral feeding formula was desiccant and devoid of any liquid formula within the carton. A quarter sized amount of dried formula was observed on the inside of the bottle was dry and cracking. The written date on the carton (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	was [DATE] (NO TIME), indicating the date the formula was last changed. A clear tube was observed connected to R1's gastrostomy tube. Within the tubing was dry residual formula occupied less than 10% of the overall length of tubing. V7 assessed the alarm from the pump, and said the alarm was from an issue like the tube feeding not administering. V7 stopped the tube feeding and disconnected the tubing from the R1's gastrostomy tubing. V7 observed the feeding carton and identified the carton contained 1 liter of 2 cal. HN. V7 confirmed the observation that the enteral feeding carton and tubing appeared dry. V7 read the date at the top of the carton and affirmed [DATE] was the last date the enteral feeding was hung. V7 explained R7's tube feeding order is for 40 mL per hour, starting at 2pm and off at 10 AM. V7 stated, No, this is not good. R1 definitely should have had another (carton) administered by now based on order. It should have been dated at least [DATE] and changed yesterday, I don't know what happened here. On [DATE] at 11:03 AM, a second surveyor confirmed the carton observation. V2 (Director of Nursing) observed the carton and confirmed the observations. V2 stated, Yes, this carton was last hung on [DATE] and it runs at 40 cc an hour. Surveyor calculated the amount of enteral feeding based on the physician's order and total volume of the carton to last R1 approximately 25 hours from [DATE]. This was confirmed with V2. V2 stated, Yes, another carton should have been hung yesterday. V2 stated R1 is completely dependent on staff for enteral feeding/hydration. When asked what complications of the carton are not being changed/feeding not being administered, V2 stated, someone could get an infection. Record review of R1's progress notes confirm no progress notes were written between [DATE] and [DATE]. On [DATE] at 3:10 PM, V6 documented, Resident (R1) received in bed with HOB elevated, VSS, due meds given as ordered. GTF on going, on at 2pm off at 10am, trach/g-tube site intact, no s/s of infection. suprapubic cath draining amber yellow urine. Writer is notified of resident's secretion is greenish yellow. PA (Redacted) is made aware and reordered to do sputum cx and cbc bmp in am. Respiratory made aware to collect sputum. Resident repositioned q2h, kept clean and dry. call pad within reach. There is no documentation affirms any provider was made aware of the missing enteral feeding or a rationale as to why R1's feeding was not administered. On [DATE] at 10:38 AM, V1 (Administrator) confirmed V1 is the abuse prevention coordinator. V1 was asked what would happen to a reasonable person if they didn't get nourishment for a day. V1 replied, If I didn't get nourishment for a day other than being hungry, I'd be upset. V1 confirmed providing enteral feeding is a service the facility is able to provide. On [DATE] at 2:53 PM, V23 (Registered Nurse) affirmed V23 worked on [DATE] but was not assigned to R1. V23 stated, No I have never been assigned that set of patients. I don't even know who (R1) is. On [DATE] at 11:21 AM, V43 (Registered Dietician) affirmed V43 is the dietician for the facility and is familiar with R1. V43 explained the purpose of enteral feeding is to ensure a resident's nutritional needs are met without oral intake. V43 confirmed R1's physician order is nothing by mouth (NPO) and 100% of R1's nutritional needs are delivered by the tube feeding. V43 affirmed R1 has a history of diabetes, protein calorie malnutrition, and dysphagia, and the tube feeding is in place because R1 cannot tolerate oral intake with dysphagia. V43 recalled R1 was admitted to the facility with the gastrostomy tube and has always been dependent on staff for nutrition. V43 affirmed staff should be following the physician orders and V43's dietary recommendations. V43 stated, I spent time calculating all of (R1's) nutritional needs, they should be following. V43 explained if a reasonable person did not get enteral feeding for extended period of time, they obviously wouldn't get adequate (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	nutrition and stated, You know, it would be similar to a normal person and what they would experience if they didn't eat for an entire day. You would be very hungry, have headaches, feel irritable, have weakness. V43 affirmed the tube feeding should not have been last hung on [DATE] and stated, Wow 3/21 to 3/23 .'s almost like 2 days without feeding. On [DATE] at 1:57 PM, V6 (Licensed Practical Nurse) affirmed V6 was assigned to care for R1 on [DATE] from 7:00AM-3:00PM. V6 recalled the R1's enteral feeding was checked around 10:00AM when it was turned off. V6 denied V6 hung a new carton of formula during the shift and feeding was to resume at 2:00PM. When asked why the new formula was not hung, V6 stated, I don't know I think I saw a little bit left in there. I don't recall (restarting it). On [DATE] at 10:37 AM, V47 (Medical Director) affirmed V47 is a medical doctor (MD) and the medical director of the facility. V47 explained if a patient with a history of diabetes and does not receive enteral feeding as ordered, you would expect the patient to have hypoglycemia (low blood sugar), dehydration, or electrolyte imbalances. On [DATE] at 2:22 PM, V61 (Licensed Practical Nurse) affirmed V61 worked both the PM and NOC shift on [DATE]. V61 denied V61 was assigned to R1 and stated, No, I had the other resident assignment. V61 said V61 recalled seeing R1 in bed while passing by R1's room at the start of the shift but did not enter the room, observe the tube feeding set, or hear any alarms coming from the room. On [DATE] at 5:25 PM, V24 (Registered Nurse, Nurse Supervisor) affirmed V24 worked on [DATE] on the PM shift. V24 did not recall who R1 was and stated, Yeah I won't know who is unless I am standing in front of them or can see them. I am not at the facility-- I was just working my other job as a nursing instructor. I haven't been employed at the facility for very long. My assignment set was up to room (which includes R1's room). If (R1) was in my set, then yeah, I took care of (R1). V24 denied ever changing any tube feeding cartons while working shift. V24 recalled doing rounds on all the patients and no one's tube feeding was alarming. V24 recalled 2 residents who received 2 cal, needed more tube feeding to be administered at the end of the shift. V24 could not recall which residents needed more tube feeding. V24 explained, I did not change them, that is night shifts responsibility to change the tube feeding set at midnight and hand more tube feeding if needed. I told (V66) in report the two residents needed more feeding hung. (V66) asked me if she writes the date of the start of the shift or the date at midnight. I told her it should be dated for the date at midnight when the set is changed. That is our standard, we document the date the feeding is hung and night shift is responsible for changing out the sets. (V66) was aware of (expectation). Record review of the facility staffing records documents in part on [DATE], V6 (Licensed Practical Nurse), V23 (Registered Nurse) were assigned to R1's unit for AM (7AM-3PM) shift, V61 (Licensed Practical Nurse) and V24 (RN Floor Manager) for PM shift (3PM-11PM), and V61 and V66 (Agency Registered Nurse) for NOC shift (11PM-7AM). During this survey, surveyor attempted to contact V66 (Agency Registered Nurse) multiple times for interview and was unable to complete an interview prior to the exit of the survey. Facility policy titled Tube Feeding Management documents in part, Nasogastric, gastrostomy, and jejunostomy tubes are used when an alternate method of nutrition is needed .1. Continuous tube feedings are based upon a 22-hour consumption period or other time frame based on individual resident need per Registered Dietician assessment and delivered over a 24-hour period .6. The Health (continued on next page)

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	145419	A. Building B. Wing	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Elmwood Park	7733 West Grand Avenue Elmwood Park, IL 60707

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Care Provider should be notified if tube-feeding amount is not infused as ordered .10. The tube feeding will be labeled with the resident's name, rate, total volume, date, and time hung . FEEDING PUMP:1. Use a feeding set for pump and assemble per manufacturer instructions. 2.Turn on pump, set prescribed rate and start feeding. 3. Flush the tube with water as ordered. 4.Pump should be cleared at the end of each shift. 5.Document tube feeding delivered. 6.Alert Health Care Provider of any issues or concerns.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure there was sufficient staffing for the respiratory (ventilator) unit to meet the resident's needs. This failure affects all 32 residents that reside in the respiratory unit. Findings include: V2's (Director of Nursing/DON) e-mail, dated 3/28/26, documents, in part, there were 32 residents reside on the third floor. All 32 residents were dependent on staff to meet all or some of their daily needs. There were 16 residents were on ventilators. There were 29 residents have a tracheostomy. There were 22 residents have a gastrostomy tube. There were 15 residents with wounds. Record review of facility schedule, 3/24/26, documents V23 (Registered Nurse/RN) and V25 (Registered Nurse/RN/Agency) were assigned to provide care to the residents on the third floor. On 3/24/2026 at 9:58am, V23 (Registered Nurse/RN) said, I still have a few residents to pass medications on. They (medications) are going to be given late. There definitely needs to be a third nurse for this floor (third floor). My medications are late every day on this floor (third floor). It's not possible to pass all the residents I'm assigned to medications on time. There are a lot of residents have gastrostomy tubes, and it's time consuming cause you have to check placement, residual, crush meds, flush. There's a lot. And then if a resident has to be sent out to the hospital or is experiencing issues, the whole day is over. I'm grateful we have respiratory staff, but we (third floor) still need a third nurse. On 3/24/26 at 10:07am, V24 (Registered Nurse/RN/Floor Manager) said, They (facility) asked me to come in and help until the agency nurse got here. I passed 2 residents' medications because of behaviors. Yes, the rest of the residents' medications were due by 10:00am. The medications are scheduled for 9:00am. I was assessing and checking on residents, and then I started to pass the medications. I am going to stay and help the agency nurse pass the residents' medications. On 3/24/26 at 10:08am, V25 (Registered Nurse/RN/Agency) said, I just got here. I'm getting report on the residents. I have 19 residents for my assignment. There are 17 residents left still need their morning medications. Yes, the medications are scheduled for 9:00am so the medications are due by 10:00am. Yes, it's passed 10:00am so the residents will be receiving their medications late. Record review of Third Floor residents Medication Administration Audits shows 16 out of 32 residents (half the amount of residents) on the third floor received their medications late on 3/24/26. Residents assigned to both V23 (Registered Nurse/RN) and V25 (Registered Nurse/RN/Agency) received medications late. R1's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R1's medications were due for 9:00am: Glycopyrrolate was given at 11:00am (one hour late); Levetiracetam was given at 11:03am (one hour and 3 minutes late); Famotidine and Losartan Potassium was given at 10:59am (59 minutes lates); Lactulose and Docusate Sodium were given at 11:04am (one hour and 4 minutes late), Baclofen and Simethicone were given at 11:05am (one hour and 5 minutes late); Heparin Sodium was given at 11:08am (one hour and 8 minutes late); and Carvedilol and Carboxymethylcelluose Sodium were given at 11:12am (one hour and 12 minutes late). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's face Sheet documents diagnoses include but are not limited to respiratory failure, type 2 diabetes mellitus, dysphagia, pressure ulcer of right buttocks, traumatic brain injury, epilepsy, gastrostomy, and tracheostomy. R4's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R4's medication was due for 8:00am: Hydralazine was given at 9:47am (47 minutes late). R4's face sheet documents diagnoses include but are not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, chronic respiratory failure, anoxic brain damage, type 2 diabetes, right and left above knee amputation, aphasia, and requires oxygen. R7's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R7's medication were due for 7:00am: Gentamicin Sulfate was given at 10:37am (2 hours and 37 minutes late); R7's medication were due for 8:00am: Diclofenac Sodium was given at 10:37am (1 hours and 37 minutes late);and R7's medication were due for 9:00am: Multivitamin, Ascorbic Acid, Magnesium Oxide, Simethicone, Vitamin B-1, MiraLAX, and Levetiracetam were given at 10:37am (37 minutes late). R7's face Sheet documents diagnoses include but are not limited to respiratory failure, paraplegia, pressure ulcer, gastrostomy, and tracheostomy. R9's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R9's medication were due for 9:00am: Quetiapine Fumarate, Docusate Sodium, Gabapentin, Senna-Docusate Sodium, multivitamin, Famotidine, and Ferrous Sulfate were given at 12:09pm (2 hours and 9 minutes late). R9's face Sheet documents diagnoses include but are not limited to respiratory failure, gastrostomy, dependent on ventilator, quadriplegia, and pressure ulcer. R10's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R10's medications were due for 9:00am: Metoprolol tartrate, Acidophilus, and Gabapentin were given at 12:34pm (2 hours and 34 minutes late). R10's face sheet documents diagnoses include but are not limited to respiratory failure, chronic obstructive pulmonary disease, diabetes, and pressure ulcer. R11's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R11's medication was due for 9:00am: Morphine Sulfate and Lorazepam were given at 10:22am (22 minutes late); and Keppra, Senna Plus, and Aspirin were given at 1:21pm (3 hours and 21 minutes late). R11's face Sheet documents diagnoses include but are not limited to respiratory failure, anoxic brain damage, pressure ulcer, gastrostomy, and tracheostomy. R12's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R12's medication was due for 9:00am: Valproic Acid, Midodrine HCL, Folic Acid, Risperdal, and Amiodarone were given at 12:36pm (2 hours and 36 minutes late). R12's face Sheet documents diagnoses include but are not limited to respiratory failure, epilepsy, pressure ulcer, gastrostomy, and tracheostomy. R24's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R24's medications were (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	due for 9:00am: Benztropine Mesylate, Loratadine, Gabapentin, Baclofen, Multivitamin, Famotidine, Heparin, Vitamin D3, Atorvastatin Calcium, Valproic Acid, Ferrous Sulfate, and Zenpap were given 31 minutes late at 10:31am. R24's medication Fluphenazine was due for 8:00am was given at 10:30am (one hour and 30 minutes late). R24's face sheet documents diagnoses include but are not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic respiratory failure, aphasia, unspecified open wound of right hand, unspecified open wound right foot, dependence on supplemental oxygen, tracheostomy and gastrostomy. R38's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R38's medications were due for 8:00am: Glycopyrrolate and Baclofen were given at 10:35am (one hour and 35 minutes late); and R38's medications were due for 9:00am: Colace, Heparin Sodium, and Ferrous Sulfate were given at 10:35am (35 minutes late); Clonazepam, Levetiracetam, and Scopolamine were given at 10:36am (36 minutes late). R38's face Sheet documents diagnoses include but are not limited to respiratory failure, quadriplegia, epilepsy, gastrostomy, and tracheostomy. R39's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R39's medications were due for 8:00am: Metoprolol Tartrate was given at 10:41am (one hour and 41 minutes late); and R39's medications were [NAME] for 9:00am: Ferrous Gluconate, Colace, Polyethylene Glycol, Keppra, and Midodrine HCL were given at 10:41am (41 minutes late). R39's face Sheet documents diagnoses include but are not limited to respiratory failure, chronic obstructive pulmonary disease, epilepsy, gastrostomy, and tracheostomy. R95's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R95's medication was due for 8:00am: Asenapine Maleate was given at 9:21am (21 minutes late). R95's face Sheet documents diagnoses include but are not limited to respiratory failure, chronic obstructive pulmonary disease, epilepsy, gastrostomy, and tracheostomy. R120's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R120's medication was due for 8:00am: Baclofen was given at 10:39am (one hour and 39 minutes late); and R120's medications was due for 9:00am: Tylenol, Valproate Sodium, Clobazam, Eliquis, Furosemide, Sennosides, Lactulose, Amiodorone, Gabapentin, Levetiracetam, Cholecalciferol, were given at 10:40am (40 minutes late). R120's face Sheet documents diagnoses include but are not limited to anoxic brain damage, respiratory failure, pulmonary edema, tracheostomy and pressure ulcer. R171's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R171's medications were due for 9:00am: Baclofen and Chlorhexidine Gluconate were given at 10:25am (25 minutes late); Daptomycin IV, Metoprolol Tartrate, Docusate Sodium, Keppra, and Folic Acid were given at 10:26am (26 minutes late); Hydroxychloroquine Sulfate was given at 10:28am (28 minutes late); and Prednisone and Thiamine were given at 10:29am (29 minutes late). R171's face Sheet documents diagnoses include but are not limited to respiratory failure, dependence (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on ventilator, gastrostomy, and tracheostomy. R172's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R172's medication were due for 8:00am: Debrox Otic solution was given at 12:31pm (3 hours and 31 minutes late); and R172's medications were due for 9:00am: Loratadine, Folic Acid, Metoprolol Succinate ER, and Eliquis were given at 12:28pm (2 hours and 28 minutes late); Ascorbic Acid, Cholecalciferol, Docusate Sodium, Symbicort Inhalation, Aripiprazole, and Amiodarone were given at 12:29pm (2 hours and 29 minutes late; and Ferrous Sulfate was given at 12:31pm (2 hours and 31 minutes late). R172's face Sheet documents diagnoses include but are not limited to chronic obstructive pulmonary disease, respiratory failure, type 2 diabetes, quadriplegia, and end stage renal disease. R190's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R190's medications were due for 9:00am: Aspirin, Metoprolol tartrate, and Loratadine were given at 10:39am (39 minutes late); Risperidone was given at 10:40am (40 minutes late); and Ascorbic Acid was 10:46am (46 minutes late). R190's face sheet documents diagnoses include but are not limited to anoxic brain damage, atrial fibrillation, dysphagia, respiratory failure, gastrostomy, tracheostomy, and pressure ulcer stage 4. R192's Medication Admin Audit Report, dated 3/25/26, documents on 3/24/26, R192's medication were due for 8:00am: Baclofen was given at 10:34am (one hour and 34 minutes late); and R192's medications were due for 9:00am: Erleada, Buprenorphine HCL-Naloxone HCL, multivitamin, Duloxetine HCL, Polyethylene Glycol, Orgovyx, and Prednisone were given at 10:34am (34 minutes late). R192's face sheet documents diagnoses include but are not limited to cerebral infarction, congestive heart failure, and cord compression. On 3/25/26 at 2:34pm, V2 (Director of Nursing/DON) said, There was a call off so V23 (Registered Nurse/RN) came to be the nurse until the agency nurse came in. nurse (V23/Registered Nurse/RN) is kinda slow. She (V23) said she (V23) was assessing residents, which is the reason for only 2 medications being late. I believe 2 nurses for the third floor are enough to provide the care the residents need. Yes, I worked the third floor once on night shift. Medications are due one before or one hour after the scheduled time. I do expect medications to be given on time. V2 affirmed giving a medication more than one hour passed the schedule time is technically a timing medication error and the physician should be notified. Record review of facility policy titled, Staffing, dated 9/2025, documents, in part, To have appropriate numbers of staff available to meet the needs of the residents. The Facility must have sufficient nursing staff with the appropriate competencies and skills set to provide nursing and related services to assure resident safety and attain or maintain the highest practical physical mental and psychological well-being of each resident as determined by the resident assessments and individuals plan of care and the number acuity and diagnosis of the facility's resident population in according with the resident assessment. Staffing is then increased based on the needs of the resident population. Record review of facility's policy titled, Medication Administration, dated 9/2025, documents, in part, All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Check medication administration record prior to (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administering medication for the right medication, dose, route, patient/resident and time. Verify the medication is being administered at the proper time, in the prescribed dose, and by the correct route. If the medication is given at a time different from the scheduled time, document the reason why. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner (depending on the situation), and a note should reflect the situation in the resident's medical record. Record review of facility policy titled, Resident Rights, dated 9/2024, documents, in part, It is the facility's policy to identify and provide reasonable accommodation for resident needs and preferences except when it would endanger the health or safety of the resident or other residents. The facility will provide a safe, clean, comfortable, and homelike environment. Record review of facility staffing records from 3/9/2026-3/25/2026 documents in part 2 licensed nurses per shift worked on the 3rd floor respiratory unit. Facility Assessment (10/01/2025) documents in part the third floor is a respiratory floor takes care of respiratory patients with complex health needs including ventilators. Additionally, the staffing plan identifies all units require 2 licensed nurses per unit and per shift. On 3/24/2026 3:35 PM, V69 (Registered Nurse) affirmed V69 works as needed and is scheduled regularly on the 3rd floor unit. V69 explained, I have to be honest, no there is not enough nurses on the 3rd floor. We really need a third nurse. These patients are very acute, most are on ventilators and have trachs, g-tubes. It feels like all I can do is pass medication and by the time my shift is over, I have just been passing meds the whole time. I try to answer call lights when I can but it's very hard. There are residents with a lot of needs, families with a lot of needs. It's not very safe. The CNAs are pretty on top of things and what they can do within their job, it's just the amount of nursing tasks are very difficult. On 3/25/2026 at 2:22 PM, V61 (Licensed Practical Nurse) affirmed V61 regularly works on the 3rd floor. V61 explained, the third floor is the heaviest and the residents there require the most amount of care of any unit. You can ask any nurse; they will tell you unit needs another nurse. It's the amount of things you have to do for the patients. Most have ventilators, tube feedings, need medications. They need a lot of care. When we give them the adequate care they need, we are not able to get things done like processing physician orders or relaying labs in a timely manner. If we can get to it by the end of our shift. Overnight telehealth is on call to cover and it's just not the same as calling their regular provider for continuity of care. Then you have a lot of families in unit, and a lot of them require a lot of your time. Sometimes, they will even be in your face yelling at you. On 3/25/2026 at 3:26 PM, V8 (Infection Preventionist) affirmed V8 is familiar with the respiratory unit. V8 stated, [NAME], I really do think you need a 3rd nurse up there (in the respiratory unit). The patients have a lot of needs and can decline very rapidly based on their health.