STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145441	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelbyville Manor	1111 West North 12th Street Shelbyville, IL 62565

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the dignity of one resident (R68) out of one reviewed for dignity in a sample list of 35. Findings include: R68's undated Face Sheet documents R68's medical diagnoses as Alzheimer's Disease, Anxiety, Schizoaffective Disorder Bipolar Type, Difficulty in Walking, Abnormal Posture, Violent Behavior, Syncope and Collapse. R68's Minimum Data Set (MDS) dated [DATE] documents R68 as severely cognitively impaired. This same MDS documents R68 as being dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers. On 4/29/25 at 2:55 PM, V17 and V18, Certified Nurse Aides (CNAs) were assisting R68 from his room on 700-hall to the shower room on the 100-hall. R68 was reclined back in a mesh slatted shower recliner chair with his left shoulder, left trunk, left buttock and left thigh all visible. R68 was wearing only a thin bath blanket laid over the top of him. Another resident and staff members were sitting at the nurse's station at the same time V17 and V18 pushed R68 by to the shower room. On 4/29/25 at 2:57 PM V8, Licensed Practical Nurse (LPN), stated the staff will undress R68 in his room and then transport him to the shower room. V8 stated it is too much work for the staff to transfer R68 in the shower room. On 4/29/25 at 3:45 PM V9, R68's Power of Attorney (POA), stated R68 was a minister his entire life and would not appreciate being unclothed in public. V9 stated R68 has advanced Alzheimer's Disease and is not able to speak for himself but was very modest in his earlier years and would be very embarrassed by being exposed in public. On 4/30/25 at 11:00 AM, V1, Administrator, stated all residents should be covered appropriately when being transferred to the shower room. V1 stated the 100-hall shower room is large enough to accommodate the total body mechanical lift and the reclining shower chair. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Resident Rights revised 11/28/2017 documents the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance of enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent an incident of staff to resident physical and verbal abuse and failed to provide adequate supervision to prevent a resident-to-resident incident of physical abuse. This failure affects two residents (R76 and R62) out of four reviewed for abuse on the sample list of 35. This failure resulted in R62 suffering a high level of pain and a bump on the head. Findings include: 1. The facility's Initial Incident Report dated 3/21/25 documents an allegation reported from a family member (V23) that a Certified Nursing Assistant (V22) had used profanity towards a resident (R76) and then had put his hands on the shoulders of R76 to restrict and confine R76 to stay seated in the wheelchair. On 4/29/25 at 10:26 AM, R76, having severe cognitive impairment and Dementia, stated he had no recollection of the incident involving the allegations against V22. On 5/1/25 at 11:01 AM, V1, Administrator, confirmed there was an allegation against V22 reported by the family member of R2 alleging that V23 had used profanity and pushed R76 into his wheelchair. V1 further confirmed V22 had been terminated for his comments (profanity). V1 stated she had spoken with V22 who told her he did place his hands on R76's shoulders to guide him from getting up from the wheelchair but that V22 told her he did not put any pressure on R76's shoulders. On 5/1/25 at 1:50 PM, V23, Family Member of R2, stated R2 was admitted to the facility on [DATE]. V23 stated she had been at the facility with R2 less than one hour when she noticed R76 seated by the entrance door for the facility's Dementia unit. V23 stated R47 was standing next to R76 and R47 had his hand on R76's wheelchair armrest. V23 stated R76 leaned forward like he was going to try to see if the door would open, then V23 witnessed V22, Certified Nursing Assistant, come up behind R76's wheelchair and violently, aggressively, and quickly jerk R76's wheelchair backwards. V23 stated at that time, V22 said to R76, Where the f**k (expletive) do you think you're going? V23 stated that R76 never did try to stand up, just leaned forward as if to try to open the door. V23 stated she was surprised that when V22 jerked the wheelchair, that R76 did not fall out, and was surprised that R47 did not get knocked to the floor. V23 stated she had worked as a Certified Nursing Assistant off and on for about 30 years and had never witnessed anything like what V22 did. R2's Face Sheet dated 5/1/25 confirmed R2 was admitted to the facility 3/21/25. Through the survey period 4/29/25 through 5/2/25, V22 was not available for a requested interview. V22's Employee Disciplinary Action form dated 3/21/25 documents V22 was dismissed/ terminated from employment due to violating facility policy by being discourteous, rude, and harassing a customer. V22's Employee Disciplinary Action dated 1/21/25 documents V22 received a written warning for using profanity while working in the hallway in the presence of residents, as reported by a (unidentified) family member. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	V22's Employee disciplinary Action dated 10/17/24 documents V22 received a written warning for, as reported by a (unidentified) family member, being in the dementia unit office using his cell phone while leaving residents unsupervised, and this family member found his beloved resident to be incontinent of a large amount of urine and having soiled clothing. The facility's Abuse Prohibition and Reporting policy dated 11/28/19 documents the facility actively prohibits resident abuse including corporal punishment and protects residents from any kind of abuse such as verbal, physical, and corporal punishment. This policy defines verbal abuse as oral disparaging and derogatory remarks to a resident or their families within their hearing. This policy defines physical abuse as any infliction of injury on a resident by any means other than accidental, including attempting to control behavior by corporal punishment. 2. Throughout the survey period 4/29/25 through 5/2/25, R76 was observed being in a one-to-one supervision from facility staff. On 4/29/25 at 10:30 AM, V5, Certified Nursing Assistant, stated the reason why she was sitting in a one-to-one duty with R76 was because R76 had hit another resident (R62) with a plastic bubble wand. At this same date and time R76 stated he had no recollection of this incident. On 5/1/25 at 11:01 AM, V1, Administrator, confirmed there had been an incident when R76 hit R62 with a plastic bubble wand. The facility's Initial Incident Report dated 4/3/25 documents an allegation made by a facility Certified Nursing Assistant (V26) that R76 had entered the room of R62, both V26 and R62 told R76 to leave the room but R76 did not comply with the request and picked up an object, later determined to be a plastic bubble wand, and began to hit R62 in the head and face. On 5/1/25 at 3:40 PM, R62 stated she had no recollection of the incident. On 5/1/25 at 3:52 PM, V26, Certified Nursing Assistant, stated he was in a resident's room directly across the hall from R62's room when he saw R76 go into R62's room. V26 stated he had called out to R76 to not go into that room, but he could not leave the resident he was providing care to. V26 stated R76 did not comply with his request to not go into the room. V26 stated that R62 likewise told R76 to get out of her room, but again, R76 did not comply. V26 stated R76 then picked an object up from R62's dresser and began to hit R62 on the head and face with it, causing R62 to fall to the floor. V26 stated when he was able to get to R76, the object was a plastic bubble wand. V26 stated he asked a co-worker to report this incident to the nurse (V28) while he monitored R76. R76's Nurses Note dated 4/3/25 at 1:21 AM, documented by V28, Licensed Practical Nurse, documents R76 struck another resident (R62) in the head with a bubble wand causing injury to R62. R76's Nurses Notes document multiple weekly incidents of R76 being verbally and physically aggressive towards staff. R62's Nurses Note dated 4/3/25 at 12:15 AM, documented by V28, Licensed Practical Nurse, documents R62 was noted to have a bump on the side of her head measuring 3 centimeters long by 2 centimeters wide by 3 centimeters high and slight purple bruising on her left ear. This note further documents R62 was complaining of dizziness and a headache, with a pain rating of eight out of ten.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit (submit) Minimum Data Set Resident Assessment Instruments to the Centers for Medicare and Medicaid within the required time frames. This failure affects five residents (R18, R49, R52, R54, and R58) out of five reviewed for Minimum Data Set transmission on the sample list of 35. Findings include: 1. R58's Minimum Data Set (MDS) dated with an Assessment Reference Date (ARD) of 2/21/25 was documented on the facility's CMS (Centers for Medicare and Medicaid) Submission Report dated 4/29/25, documenting R58's MDS was submitted on 4/29/25. 2. R52's MDS dated with an ARD of 2/4/25 was documented on the facility's CMS Submission Report dated 4/29/25, documenting R52's MDS was submitted on 4/29/25. 3. R49's MDS dated with an ARD of 2/18/25 was documented on the facility's CMS Submission Report dated 4/23/25, documenting R49's MDS was submitted 4/23/25. 4. R18's MDS dated with an ARD of 2/18/25 was documented on the facility's CMS Submission Report dated 4/29/25, documenting R18's MDS was submitted 4/29/25. 5. R54's MDS dated [DATE] was documented as In Process on 4/30/25, documenting this MDS was not yet completed or transmitted. On 4/30/25 at 3:15 PM, V20, Minimum Data Set Coordinator, confirmed she had just submitted (transmitted) MDSs for R58, R52, and R18 on 4/29/25. V20 further confirmed she had submitted R49's MDS on 4/23/25. V20 stated the MDS for R54 was not yet completely coded into a form to be able to be submitted to CMS. V20 then stated and confirmed that there is a timing process for the MDS in which was there is an allowance for 14 days after the ARD to do the actual assessment of the resident, another 7 days to have the MDS electronically coded in a form to be able to be transmitted, and another 7 days to transmit (submit) the MDS to CMS. V20 concluded by stating R58's MDS should have been transmitted by 3/21/25, R52's MDS should have been transmitted by 3/4/25, R49's and R18's MDS should have been transmitted by 3/18/25, and R54's MDS should have been transmitted by 4/8/25.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. R12's Face Sheet dated 5/1/25 documents R12 was admitted to the facility 12/31/18. R12's original Interagency Certification of Screening Results (Level 1 PASRR) dated 12/27/18 documents no reasonable basis to suspect R12 had any mental illness or developmental disability diagnoses. R12's Face Sheet dated 5/1/25 documents R12 was diagnosed with Psychotic Disorder with Delusions (severe mental illness) on 5/28/19. There was no Level 2 PASRR in R12's comprehensive medical record. 3. R26's Face Sheet dated 5/1/25 documents R26 was admitted to the facility 11/14/19 under hospice services, and did not require a Level 1 PASRR. This same Face Sheet documents R26 was diagnosed with Bipolar Disorder (severe mental illness) on 7/6/20. R26's original Interagency Certification of Screening Results dated 12/30/20, after R26 no longer required hospice services, documents there was no reasonable basis to suspect R26 had a mental health or developmental disability diagnosis. There was no Level 2 PASRR in R26's comprehensive medical record. 4. R45's Face Sheet dated 5/1/25 documents R45 was admitted to the facility 9/13/21. R45's original Interagency Certification of Screening Results dated 9/13/21 documents no reasonable basis to suspect R45 had a mental illness or developmental disability diagnosis. R45's Face Sheet dated 5/1/25 documents R45 was diagnosed with Psychosis (severe mental illness) on 2/29/24. There was no Level 2 PASRR in R45's comprehensive medical record. On 4/30/25 at 10:45 AM, V19, Business Office Manager, stated the facility staff had received training from the (screening agency) back in 2023, when this new PASRR process started, who told the facility staff to do a PASRR on the new residents coming into the facility. V19 further stated the (screening agency) never said anything about doing a PASRR Level 2 on the people who were already in the building. On 5/1/25 at 11:01 AM, V1. Administrator stated she has become aware of the lack of obtaining Level 2 PASRR's and is understanding the Level 2 needs to be completed for residents with a mental health diagnosis. V1 further stated the facility will be doing the Level 2 PASRR going forward. Based on interview and record review the facility failed to obtain a Level 2 Pre-admission Screening and Record Review (PASRR) for four (R12, R26, R45, R68) residents out of six reviewed for PASRR in a sample list of 35. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings include: 1. R68's undated Face Sheet documents R68 admitted to the facility on [DATE]. R68's Pre-admission Screening and Record Review (PASRR) dated 1/26/24 documents R68 did not require a Level 2 PASRR. R68's Face Sheet documents R68 was diagnosed with Schizoaffective Disorder, Bipolar type on 10/16/2024. The facility was unable to provide documentation of a Level 2 PASRR being completed after R68 was diagnosed with a new mental health disorder on 10/16/2024. On 4/30/25 at 3:00 PM V19 Business Office Manager (BOM) stated the facility did not complete a Level 2 PASRR for R68. V19 stated V19 was under the impression after admission a Level 2 PASRR would only be completed if the resident had a significant change. On 5/2/25 at 9:00 AM V1 Administrator stated the facility had only been completing the Level 2 PASRR's with a resident's significant change. V1 Administrator stated she was not aware that the facility needed to complete a Level 2 PASRR with any resident who is diagnosed with a Mental Illness after admission. V1 Administrator stated the facility will be obtaining this Level 2's from this point forward. The facility policy titled Pre admission Screening and Resident Review (PASRR) adopted 2/17/25 documents the facility will complete a Level I PASRR and a Level 2 PASRR if required. Residents with Mental Illness (MI) diagnoses or Psychotropic medications may have a determination indicating that a PASRR Level 2 is required. If this is indicated, the facility shall ensure that any recommendations identified on the Level 2 screen have been incorporated into the care plan. The facility shall resubmit a PASRR for any resident who has had a significant change in status, as identified through the Minimum Data Set (MDS) process, received an order for a first-time psychotropic medication, and/or receives a new MI diagnosis.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain a Level 2 Pre-admission Screening and Record Review (PASRR) for one resident (R46) out of six reviewed for PASRR's in a sample list of 35. Findings include: R46's undated Face Sheet documents R46 admitted to the facility on [DATE]. This same face sheet documents R46 was diagnosed with Major Depressive Disorder with recurrent Psychotic Symptoms on 2/5/2025. R46's Level 1 Preadmission Screen and Record Review (PASRR) dated 6/5/2020 documents R46 does have an Intellectual Disorder (ID). The facility is unable to provide documentation of a Level 2 PASRR being completed. On 5/2/25 at 9:00 AM V1 Administrator stated the facility had only been completing the Level 2 PASRR's with a significant change. V1 Administrator stated she was not aware that the facility needed to complete a Level 2 PASRR with anyone with an Intellectual Disability (ID). V1 Administrator stated the facility will be obtaining this Level 2's from this point forward. The facility policy titled Pre-admission Screening and Resident Review (PASRR) adopted 2/17/25 documents the facility will complete a Level 1 PASRR and a Level 2 PASRR if required. Residents with Mental Illness (MI) diagnoses or Psychotropic medications may have a determination indicating that a PASRR Level 2 is required. If this is indicated, the facility shall ensure that any recommendations identified on the Level 2 screen have been incorporated into the care plan. The facility shall resubmit a PASRR for any resident who has had a significant change in status, as identified through the Minimum Data Set (MDS) process, received an order for a first-time psychotropic medication, and/or receives a new MI diagnosis.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a cognitive impaired resident, who required substantial to maximum staff assistance, with a safe transfer and toileting. This failure resulted in R57 sustaining two fractures on 3/12/25, that required emergency medical attention and surgical repair. The facility also failed to initiate targeted post-fall interventions to address the root cause of self-toileting. These failures affected one of three residents (R57) reviewed for falls on the sample list of 35. Findings include: R57's Minimum Data Set, dated [DATE] documents R57's Brief Interview for Mental Status score was 12 out of a possible 15, indicating moderate cognitive impairment. The same MDS inaccurately (according to V20, MDS/Care Plan Coordinator and V27, Nurse Practitioner below interviews) documents R57 had no falls prior to admission to the facility. R57's Face Sheet documents his admission date as 3/6/25. The same Face Sheet includes the following diagnoses: Dementia in Other Diseases, Classified Elsewhere, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Other Lack of Coordination, Difficulty in Walking, Not Elsewhere Classified, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites. R57's admission assessment dated [DATE], documents: R57's Fall Risk Score of 16 (High Risk), using the following fall risk scale: Scoring: 0-5 Total Points equals Low Fall Risk, 6-13 Total Points equals Moderate Fall Risk, greater that 13 Total Points equals High Fall Risk. R57's Physical Therapy (PT) Evaluation and Plan of Treatment dated 3/6/25 documents R57's diagnoses as follows: Urinary Tract Infection, Site Not Specified, Difficulty in Walking, Not Elsewhere Classified, and Muscle Wasting and Atrophy, not elsewhere classified, Multiple Sites. The same PT evaluation document: R57 required substantial/maximal staff assistance with transfers. R57's Resident Care Information Certified Nursing Assistants Task sheet dated 3/10/25 directs staff to transfer R57 with one assist, front wheeled walker and to use a gait belt. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R57's Safety - Fall Event report documents R57 fell on [DATE] at 1:00 pm. The same report documents: Staff report resident (R57) noted to be in (on the) floor. Upon arrival, resident noted to be laying on back in (sic) floor, in front of (the) doorway, with (his) head facing (the) doorway and (his) feet facing (the) window. W/C (wheelchair) noted to be parked at foot of bed, facing window. No O2 (oxygen) on. Resident states 'I was trying to go to the bathroom, and I tripped over my heel'. Environment free of clutter. Room well lit. Call light not activated. Non-skid shoes on. Resident c/o (complained of) pain 10/10 (on a scale of 0-10, 10 being the worst pain level on the scale) to left shoulder and left hip, unable to complete ROM (range of motion). Resident states he did not hit his head, neuros (neurological assessment) WNL (within normal limits). VS (vital signs) Temperature:97.6, Pulse:70, Respirations:18, Blood Pressure: 136/72, Oxygen Saturation (blood saturation level): 90% RA (room air), Oxygen placed on resident, at 2 L/min (two liters per minute) (via) NC (nasal cannula). Resident made comfortable on floor. MD (unidentified physician) notified, N.O. (new order). Send to ER (hospital emergency room) for eval (evaluation) and tx (treatment). The same Safety-Fall Event documents: On 3/12/2025 at 3:36 pm, received call from (local hospital) ER (emergency room), ER (unidentified) nurse states resident has a fractured left shoulder and a fractured left hip and will be transferred to a higher level of care hospital. ER nurse does not know which hospital resident is being sent to at this time but will contact facility as soon as information becomes available. DON/Administrator (V2, Director of Nursing/V1, Administrator) notified. R57's Regional Level 1 Trauma Center, Acute Care Surgery Service: Emergency Surgery. Trauma, Surgical Critical Care Hospital (hospital, long distance from the facility) record, documents the following: HOSPITAL COURSE: (R57's name and age) who presented on 3/12/2025 at 6:30 PM, as a transfer from (hospital, shorter distance from the facility) after he suffered a mechanical fall at his nursing home. He was found to have left humerus fracture and left femoral neck fracture. A (name brand indwelling urinary catheter) was inserted at the previous hospital prior to transfer. Orthopedic Surgery was consulted and planned for operative intervention the next day. The same hospital record documents: He (R57) underwent in-situ fixation (surgical repair) of left femoral neck fracture on 3/13/25 with (Orthopedic Surgeon). His humeral fracture is being managed non-operatively with a sling. He is weight-bearing as tolerated to the left lower extremity, and non-weight bearing to the left upper extremity. On 4/30/25 at 10:40 am V2, DON stated (R57) was not to ambulate unless he was working with therapy. V2, DON also stated V7, Certified Nursing Assistant (CNA) was the staff member that found R57 on the floor post fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/30/25 at 10:55 am V7, CNA walked down to the empty room on 400-hall that R57 resided in when he fell 3/12/25. V7, CNA confirmed V2, DON's observation and stated (R57's) head was close to the open door of his room. His feet were directed towards the window where his wheelchair was at. I did not pay attention to if his wheelchair was locked or unlocked. I was focused on the patient (R57). (R57) said he was going to the bathroom when he fell. The bathroom is pretty far from here, where he laid. (approximately 8 feet away). I don't know if he was incontinent at the time of his fall. He was not wet on the outside of his clothes. The last time I saw him, he was in the small dining room eating about a half hour before he fell. I did not take him to the bathroom before lunch. He always took himself. He was independent (per admission and therapy notes above R57 required substantial to maximum staff assistance with transfer) when I worked. He never asked for help. For the most part he was alert and oriented (diagnoses documented above as Dementia). I don't know if he had a history of falls, he had not been here very long (admitted six days prior to the fall). On 4/30/25 at 12:40 pm V2, Director of Nursing stated (R57) was moved to the room closer to the nursing station when he returned from the hospital post fall (3/12/25). That was the intervention to increase supervision. It makes sense that we should have identified why he was trying to self-transfer. He should have had assistance. He was going into bathroom. His intervention should have included increased toileting, in addition to increasing (R57's) supervision. On 5/1/25 at 3:30 pm V27, Nurse Practitioner stated I have known (R57) long before he was a resident in the facility. He had numerous falls when he was at home. He had a very unstable gait. He should have had assistance with ambulation, transfers and toileting. He was somewhat impulsive. I was not surprised when I heard he had the fall with the fractures. I did not realize staff were not providing him the assistance he needed. He was admitted to the facility and was receiving PT (Physical Therapy) for strengthening. Yes, he should have been toileted by staff. He was trying to toilet himself, from what I understand, that was the root cause of his fall. On 5/2/25 at 1:30 pm V20, Minimum Data Set (MDS)/Care Plan Coordinator, stated R57's MDS did not document that R57 had previous falls, because the facility did not have his history when he was admitted [DATE]. He is moderately impaired and did not remember falling prior to admission. Now we know his history. The fall here in the facility 3/12/25 with fractures, is listed (documented) on the MDS because his assessment goes until midnight on 3/12/25.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 3. R16's Minimum Data Set, dated [DATE] documents R16 has an Indwelling Urinary Catheter for the diagnoses of Obstructive Uropathy. R16's current Physician Order Sheet documents the following: (name brand indwelling urinary) catheter care Q (every) shift. R16's Urine Bacteria Culture laboratory report dated 01/17/25 that documents the following urinary tract infection: Klebsiella Pneumoniae (Multi-drug Resistant Organism) equal or greater than 100,000 colony forming units per milliliter and Methicillin Resistant Staphylococcus Aureus (Multi-drug Resistant Organism) equal or greater than 100,000 colony forming units per milliliter. On 5/2/25 at 11:20 am, V33, Certified Nursing Assistant (CNA), with V2, Director of Nursing (DON), entered R16's room. V2 was present to provide R16 assistance with positioning while V33, provided indwelling urinary catheter care. R16 had a bedside, indwelling urinary catheter drainage bag, that hung from R16's bed frame. R16 had cloudy, beige sediment adhering to the inside of the indwelling catheter tubing. R16 was assisted to a back lying position with R16's legs separated. R16's urinary catheter insertion site, at the tip of the penis and the extending catheter, approximately two inches down on the external indwelling catheter tube, was soiled with dried, crusted, yellow and light brown body fluid. V33, removed her gloves after positioning and washed her hands in the bathroom. V33 donned new gloves and cleaned R16's upper inner thighs and sides of R16's testicles using disposable wipes. V33 again washed her hands and donned new gloves. V33 then used disposable wipes, and swiped R16's penis repeatedly from the base up his penis shaft, up and over the opening at the catheter insertion site, cross contaminating tip of R16's penis and catheter. V33 then used a disposable wipe with one swipe, to clean the indwelling catheter external tube, from R16's insertion site down to the junction with the bedside drainage bag tubing. V33 removed her gloves, washed her hands, donned new gloves and assisted V2 in repositioning R16 to a side lying positron. V33 repeated hand hygiene and re-gloving appropriately and V33, cleaned feces off of R16's buttocks and buttocks crease. R16 was then repositioned by V2 and V33 to a back lying position. As V33 began to pull R16's blankets up over R16, V33 confirmed she had completed R16's indwelling urinary catheter and incontinence care. This surveyor then asked V33 if she could see the external indwelling urinary catheter remained soiled with the dried, crusted, yellow and light brown body fluid. V33 confirmed R16's catheter remained soiled. On 5/2/25 at 11:40 am V2, DON stated I saw (V33, CNA) cleansed (R16's) penis in the wrong direction (towards, instead of away from the meatus). I know you wrote it down. Yes, that is cross contamination. I think she (V33, CNA) was just nervous. Based on observation, interview and record review the facility failed to prevent cross contamination during indwelling urinary catheter care for two (R16, R65) residents, and incontinence care for one (R68) resident out of four reviewed for incontinence care in a sample list of 35. Findings include: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R65's Minimum Data Set (MDS) dated [DATE] documents R65 as cognitively intact. This same MDS documents R65 is dependent on staff for toileting, dressing, bathing, bed mobility, personal hygiene and transfers. R65's Physician Order Sheet (POS) dated May 2025 documents a physician order to provide urinary catheter care every shift. R65's Physician Order Sheet (POS) dated May 2025 documents a physician order starting 4/21/25 to insert a indwelling urinary catheter monthly and as needed. R65's face sheet documents a diagnosis of Neuromuscular Dysfunction of the Bladder on 4/17/2024. On 4/30/25 at 2:30 PM, V17 and V18, Certified Nurse Aides (CNAs) completed perineal and indwelling urinary catheter care for R65. R17 CNA did not change her gloves nor use hand hygiene after providing frontal perineal care before providing R65's rear perineal care. R65's indwelling catheter drainage bag cover fell to the floor as V17 and V18 were repositioning R65. V17 picked up R65's urinary drainage bag cover and placed it back over R65's urinary drainage bag. V17 and V18 did not apply barrier cream after providing perineal care for R65. On 4/30/25 at 2:50 PM, V17, Certified Nurse Aide (CNA), stated she should have changed her gloves and completed hand hygiene between cleansing R65's front and rear perineal areas. V17 stated barrier cream should have been applied. On 4/30/25 at 3:10 PM, V2, Director of Nurses (DON), stated the staff should change their gloves when moving from one area to another if the gloves become contaminated. V2 stated V17 should have changed her gloves, provided barrier cream and obtained a new drainage dignity cover. V2 stated the facility has 'tons of dignity bags' and it is encouraged to keep them off of the floor due to infection control purposes. V2 stated the facility does not have a policy for the dignity bags but it is the expectation that staff do not put contaminated products over a urinary drainage bag. The facility policy titled Catheter Care revised June 2005 documents staff should remove gloves and wash hands after providing catheter care. The facility policy titled Perineal Care revised November 2018 documents staff should apply skin care product after completion of perineal care. 2. R68's Minimum Data Set (MDS) dated [DATE] documents R68 as severely cognitively impaired. This same MDS documents R68 as being dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers. R68's Care Plan intervention dated 4/3/24 instructs staff when (R68's) physical behaviors occurs, ensure safety and re-approach at a later time utilizing a different staff member. On 5/1/25 at 10:35 AM, V31 and V32, Certified Nurse Aides (CNAs), provided incontinence care for R68. R68 was incontinent of bladder and bowel. V32 cleansed urine and bowel movement from R68's buttocks, then applied a clean incontinence brief to R68 without changing gloves and/or using hand hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/25 at 10:50 AM, V32 Certified Nurse Aide (CNA), stated she should have removed her gloves after providing incontinence care and prior to applying a clean incontinence brief. On 5/1/25 at 11:15 AM, V2, Director of Nurses (DON), stated hand hygiene should be performed after providing incontinence care and applying a new brief.

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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 transcribe the complete physician order of the oxygen rate to be administered, and failed to ensure a Licensed nurse administered the oxygen. This failure affects one of one resident (R185) reviewed for oxygen administration on the sample list of 35. Findings include: R185's Physician Order Report sheet (POS) dated 5/1/25 documents the following diagnosis: Pneumonia, Unspecified Organism (Primary, admission Diagnosis, 4/22/25), Emphysema, Unspecified, and Viral Pneumonia, Unspecified, and Pressure Ulcer of Sacral Region, Stage II. R185's same POS documents: O2 (oxygen) at _____ (left blank) L (liters) nasal cannula continues for SOB (Shortness of Breath). On 5/1/25 at 2:00 pm V3, Registered Nurse/Wound Nurse (RN), and V7, Certified Nursing Assistant (CNA) performed hand hygiene, donned gowns and gloves and entered R185's room to provide R185's pressure ulcer treatment. R185 laid in bed with an oxygen nasal cannula prong in his nares. R185's oxygen concentrator was not turned on for R185's oxygen administration. V7, CNA, stated (R185) asked for his oxygen when he laid down. I put the nasal cannula on him. I just forgot to turn on the concentrator. R185 then stated Yeah, there is nothing coming out. V7, CNA, walked over to R185's oxygen concentrator, turned it on to deliver the oxygen, and V7, CNA set the rate of oxygen to be dispensed at two liters per minute. R185 then stated That is better, you can see the bubbles in the water bottle. Now, I am getting air. V3, RN stated to V7, CNA, from the opposite side of R185's bed, Two liters (of oxygen per minute) is correct. On 5/2/25 at 9:15 am V1, Administrator/ RN provided the facility oxygen administration policy and stated she will scan the policy to this surveyor. V1 confirmed R185's oxygen order should have included the rate of oxygen to be delivered. V1 also stated Only licensed Nurses are to administer oxygen. It is the standard of practice, and our policy. The facility policy Oxygen Therapy and Safety dated 04/09/20 documents: It is the policy of this facility to provide a safe environment for residents, staff, and the public. Purpose: To provide a source of oxygen to persons experiencing an insufficient supply of same and to address the use and storage of oxygen and oxygen equipment. The same policy documents: Licensed Nurses are to administer residents' oxygen, and a Physician order will provide the following information: when to use, how often, liter flow, and whether to use cannula or mask.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain a residents call light and bedside table within reach, resulting in a delay in pain medication administration. This failure affected one of two residents (R189) reviewed for pain on the sample list of 35. Findings include: R189's Face Sheet documents R189 was admitted to the facility 4/14/25 with the following diagnoses: Pain, Unspecified, Age-related Osteoporosis Without Current Pathological Fracture, Difficulty in Walking, Not Elsewhere Classified, Other Lack of Coordination, and Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites. R189's Minimum Data Set, dated [DATE] documents the following: R189's Brief Interview of Mental Status score as 14 out of a possible 15, indicating no cognitive impairment. R189's current Physician Order Report sheet (POS) documents the following medication order: Tramadol - Schedule IV (Narcotic pain medication) tablet; 50 mg; Amount to Administer: 1/2 tablet (25 mg); oral, twice A Day - PRN (as needed) Pain. On 04/29/25 at 12:20 pm R189 was seated in a bedside chair. R189 stated the only issue R189 has had since admission 4/14/25, was that one night in the past week (later identified as night shift 4/27/25) she laid in bed for hours with her leg hurting really bad. R189 stated the call light was not within reach and R189 tried to yell out for help, but her voice was too soft, no one heard her. R189 also said she does not have a roommate to call to assist R189 and laid in pain for hours. She stated she reported this incident that same morning (4/28/25) to a nurse, (later identified as V13, Registered Nurse), and was reassured this would never happen again. R189's Medication Administration Record (MAR) documents V13, Registered Nurse (RN)administered R189's Tramadol narcotic pain medication, on April 28 at 6:56 am. V13, RN did not document the level of pain R189 had experienced. On 4/30/25 at 2:55 pm V13, RN stated (R189) told me at breakfast that she (R189) had a bad night and was having leg pain. She (R189) said the call light and bedside table were out of her reach and she could not get a hold of staff. I do not remember off the top of my head what her pain level was. I did not chart it and should have. She (R189) is alert and oriented x4 (person, place, time and situation). She said her call light and bedside table were out of reach, overnight, she was hurting and needed staff. She was up in the dining room when I talked to her. I told (V15, Certified Nursing Assistant) to make sure both were in reach. On 4/30/25 at 3:00 pm V15, CNA confirmed she had been informed R189's bedside table and call light were out of reach. V15, CNA stated she passed this information on in report to V16, Agency CNA night shift 4/28/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 3:10 pm, V16, Agency CNA, confirmed she had been informed R189's bedside table and call light were out of reach overnight 4/27/25. V16 stated she worked 4/27/25 on R189's hall, night shift with another (unidentified CNA). V16 stated the other CNA provided R189's last round of toileting. V16, CNA stated Everybody's call light should be within reach at all times. On 5/1/25 at 3:30 pm V27, Nurse Practitioner stated She (R189) has Tramadol for pain. I had not heard from her or staff that (R189's) call light and bedside table were not available to her. This is a given. She could have used the call light to alert the nurse. She should not have had to wait until morning if she was having pain overnight. The facility Call Light policy dated 01/2004 documents: Objective: is to respond to residents request and needs. The facility policy Pain Management dated 03/03/2022 documents the following: Policy: The Facility is dedicated to the philosophy that all residents should be as free of pain as possible, through a combination of medical intervention and functional therapy. Purpose: To identify residents experiencing pain to establish control of pain to the resident's satisfaction and to relieve related symptoms. The same policy documents the facility will assess residents' level of pain every shift and document the residents level of pain using the standard pain scale of one to ten with ten being the highest level of pain.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide behavioral health services, failed to provide behavioral services training, and failed to prevent minor injuries for one (R68) resident out of two reviewed for behavioral health in a sample list of 35. Findings include: The Facility assessment dated [DATE] documents the facility has admitted 64 residents prescribed Antipsychotic Medications, and admitted 39 residents with Behavioral Health Care Needs, in the previous year. R68's undated Face Sheet documents R68 admitted to the facility on [DATE]. This same Face Sheet documents R68's medical diagnoses as Alzheimer's Disease, Anxiety, Schizoaffective Disorder Bipolar Type, Difficulty in Walking, Abnormal Posture, Violent Behavior, Syncope and Collapse. R68's Minimum Data Set (MDS) dated [DATE] documents R68 as severely cognitively impaired. This same MDS documents R68 as being dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers. R68's Care Plan intervention dated 4/3/24 instructs staff when (R68's) physical behaviors occurs, ensure safety and re-approach at a later time utilizing a different staff member. R68's Nurse Progress Note dated 2/15/25 at 9:03 PM documents R68 was combative with staff during bedtime cares, where R68 was attempting to strike staff, and subsequently acquired 2.0 centimeters (cm) long by 2.0 cm wide skin tear on R68's right forearm when he made contact with mobility equipment. This same note documents staff applied pressure to R68's right forearm to control bleeding. R68's Nurse Progress Note dated 3/18/25 at 6:22 AM documents R68 has four skin tears. Three of R68's skin tears are V shaped and measure 2.0 cm wide by 1.0 cm wide to right forearm. This same note documents R68 was physically combative when staff assisted R68 for a transfer. R68's Nurse Progress Note dated 4/29/25 at 2:50 PM documents R68 was combative when staff were getting him undressed for his shower in his room. This same note documents R68 received a L shape skin tear measuring 2.0 cm wide by 1.5 cm long. On 4/30/25 at 11:35 AM, V3, Registered Nurse (RN)/Wound Nurse/Infection Preventionist (IP), stated R68 received injuries on 2/15/25, 3/18/25 and 4/29/25 from staff while cares were provided. V3 stated R68 can be combative during care times. V3 stated she was not aware of R68's skin tear on 2/15/25. V3 stated there were not any events opened for either of these two incidents (2/15/25 and 3/19/25). V3 stated the staff should open an event if there is any injury and that way, she is alerted to follow up with a skin evaluation, notifications and orders for treatment if needed. V3 stated those two incidents were never followed up on due to V3 was not aware of the incidents. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 3:00 PM, V17 Certified Nurse Aide (CNA), stated R68 was combative when she was assisting R68 in removing his clothes to get ready for his shower. V17 stated R68 was laying in bed when V17 attempted to remove R68's shirt. V17 stated she had to get R68 ready for his shower when R68 became combative. V17 stated she pushed R68's arm out of his shirt sleeve and R68 got a skin tear on the top of his left hand because he was being combative. V17 stated she should have walked away and tried later or asked someone else to help R68. On 5/2/25 at 9:45 AM, V2, Director of Nurses (DON), stated the facility did not have any Psychiatric services prior to February 2025 when V30 Psychiatric Nurse Practitioner (NP) started seeing residents from this facility. V2 stated R68 has not yet been seen by V30 Psychiatric NP. V2 stated R68 has had behaviors since his admission in February 2024. V2 stated the facility staff has not had any training on behavioral health and/or ways to provide care for residents with behaviors. The facility policy titled Pre-admission Screening and Resident Review (PASRR) adopted 2/17/25 documents the facility will complete a Level 1 PASRR and a Level 2 PASRR if required. Residents with Mental Illness (MI) diagnoses or Psychotropic medications may have a determination indicating that a PASRR Level 2 is required. If this is indicated, the facility shall ensure that any recommendations identified on the Level 2 screen have been incorporated into the care plan. The facility shall resubmit a PASRR for any resident who has had a significant change in status, as identified through the Minimum Data Set (MDS) process, received an order for a first-time psychotropic medication, and/or receives a new MI diagnosis.